STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G559	A. BUILDING 00 B. WING	05/03/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARC OF NORTHWEST INDIANA INC, THE	2901 BEVERLY DR GARY, IN 46408

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W000000	This visit was for an extended annual recertification and state licensure survey to a full survey (Client Protections, Healthcare Services and Governing Body). Dates of Survey: 4/15, 4/16, 4/17, 4/18, 4/19, 4/23 and 5/3/13 Facility Number: 001073 Provider Number: 15G559 AIMS Number: 100239890 Surveyors: Paula Chika, QIDP-TC Christine Colon, QIDP Amber Bloss, QIDP (4/15/13 to 4/19/13) These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 5/10/13 by Ruth Shackelford, QIDP.	W000000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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W000102	483.410 GOVERNING BODY AND MANAGEMENT The facility must ensure that specific governing body and management requirements are met. Based on observation, interview and record review, the governing body failed to meet the Condition of Participation: Governing Body for 2 of 2 sampled clients (#1 and #2) and for 2 additional clients (#3 and #4). The governing body failed to ensure client #3's heath care needs were not neglected and the facility's health care services met the nursing needs of clients #1, #2, #3 and #4. The governing body failed to ensure the facility allowed clients #1 and #2 to participate in community outings, to ensure client #3's guardian was informed of the client's savings account, and of the client's inability to access her own funds. The governing body failed to ensure the facility reported all allegations of abuse/neglect to the administrator and/or to state officials for client #3, and to ensure the facility put in place corrective measures regarding an allegation of neglect for client #3. Based on interview and record review, the governing body failed to ensure the group home maintained medical documentation as related to Medication Administration Records for 1 of 4 sampled clients (Client #2).	W000102	The facilities procedure for handling consumers' funds will be modified by 5/31/13 please see W 140. The facilities method of assessing and developing plans following changes in client condition will be modified by 5/31/13 please see please see W 331, W342, and W 369	05/31/2013

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	Findings include: 1. The governing body failed to meet the Condition of Participation: Client Protections for 2 of 2 sampled clients (#1 and #2) and for 2 additional clients (#3 and #4). The governing body failed to implement written policy and procedures to prevent neglect of client #3 in regard to the client's medical needs. The governing body failed to ensure clients #1 and #2 participated in outings/activities in the community, to ensure the facility kept a complete accounting of client #1, #2, #3 and #4's monies, informed client #3's guardian of the client's saving account, to report all allegations of abuse/neglect to the administrator and/or to other officials per state law for client #3. The governing body failed to ensure corrective measures were put in place to address issues found during an investigation of neglect to prevent recurrence for client #3. Please see W122. 2. The governing body failed to meet the Condition of Participation: Health Care Services for 2 of 2 sampled clients (#1 and #2) and for 2 additional clients (#3 and #4). The facility's nursing services failed to meet the health care needs of the clients it served. The facility's health care services failed to assess, monitor and/or			

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	address clients' health care needs, and failed to ensure facility staff were trained to meet the health needs of clients #2 and #3. The facility's health care services failed to ensure all medications were administered without error for client #2. The facility's health care services failed to ensure the facility's practice in regard to times of medication administration was reviewed by client #1, #2 and #4's doctors. Please see W318. 3. The governing body failed to ensure the group home maintained medical documentation as related to Medication Administration Records for Client #2. The governing body failed to ensure the facility implemented its written policies and procedures to prevent neglect of client #3 in regard to aspiration pneumonia and falls. The governing body failed to ensure the facility allowed clients #1 and #2 to participate in activities in the community. The governing body failed to ensure the facility kept a complete accounting of the clients' finances as some financial records were not available to review for clients #1, #2, #3 and #4. The governing body failed to ensure the facility informed client #3's guardian of the amount of funds in the client's savings account held			

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	by the facility, and/or to inform the client's guardian client #3 was not able to access her funds in the local savings account as the client did not have the required credentials/paper work. The governing body failed to ensure the facility immediately reported an allegation of possible neglect to the administrator immediately and/or failed to report an allegation of neglect to the Division of Disability, Aging and Rehabilitative Services (DDARS)/BDDS (Bureau of Developmental Disabilities Services) per 460 IAC 9-3-1 (b) (5) and to Adult Protective Services (APS) per IC 12-10-3 for client #3. The governing body failed to ensure the facility took appropriate corrective measures and/or provided retraining in regard to an allegation of neglect involving client #3. The governing body failed to ensure the facility's Health Care Services met the nursing needs of the client. The governing body failed to ensure the facility's Health Care Services developed a risk plan in regard to the client's health, obtained clarification for monitoring residuals, monitored and/or assessed a client's "diaper rash," and to ensure clients' doctors were aware the clients' Medication Administration Records did not specify a specific time on when the			

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	clients' medications were to be administered to ensure the doctor agreed with the facility's practice. The governing body failed to ensure the facility's Health Care Services ensured ordered assessments were completed and a client's fall risk plan was updated for clients #1, #2, #3 and #4. The governing body failed to ensure the facility's Health Care Services ensured staff were trained in regard to aspiration pneumonia, peg tube feedings and/or provided competency based training to ensure all staff understood and knew how to adequately perform peg tube feedings and care for client #3. The governing body failed to ensure the facility's Health Care Services administered all of client #2's medications during a medication pass. Please see W104. 9-3-1(a)			

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W000104	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. Based on observation, interview and record review for 2 of 2 sampled clients (#1 and #2) and for 2 additional clients (#3 and #4), the governing body failed to exercise general policy and operating direction over the facility to ensure client #3's heath care needs were not neglected and the facility's health care services met the nursing needs of clients #1, #2, #3 and #4. The governing body failed to exercise general policy and operating direction over the facility to ensure the facility allowed clients #1 and #2 to participate in community outings, to ensure client #3's guardian was informed of the client's savings account, and of the client's inability to access her own funds. The governing body failed to exercise general policy and operating direction over the facility to ensure the facility reported all allegations of abuse/neglect to the administrator and/or to state officials for client #3, and to ensure the facility put in place corrective measures regarding an allegation of neglect for client #3. Based on interview and record review, the governing body failed to exercise general policy and operating direction over the facility to ensure the group home	W000104	Modifications to the way in which the governing body exercises operating direction will be completed by 5/31/13 please refer to Tags, W136, W140, W148, W153, W157, W331, W342, W369	05/31/2013

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	maintained medical documentation as related to Medication Administration Records for 1 of 4 sampled clients (Client #2). Findings include: 1. On 4/16/13 at 11:49 AM, the facility BDDS (Bureau of Developmental Disabilities Services) reports were reviewed from 4/16/12 to 4/1/13. A BDDS report submitted 3/6/13 indicated Client #2 was assessed by the nurse due to symptoms of excess coughing. The report indicated Client #2 was congested and was sent to the emergency room. The report indicated Client #2 was admitted to the hospital with low oxygen levels and was receiving oxygen. On 4/16/13 at 1:00 PM, Client #2's Medication Administration Record (MAR) dated March 2013 was reviewed. The MAR indicated several scheduled medications were marked as PRN (given as needed) and PRN medications for cough were administered without documentation on the back of the result of the PRN. The Nurse Manager was interviewed on 4/16/13 at 2:35 PM. The Nurse Manager indicated she would clarify Client #2's physician orders and return with the MAR documentation. The Nurse Manager and the Service			

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	Coordinator #1 indicated they would also locate Client #2's January, February, March, and April 2013 physician orders and corresponding MARs for further review. On 4/18/13 at 1:00 PM, a record review for Client #2 indicated client #2's diagnoses included, but were not limited to, mental retardation, Down Syndrome, congenital blindness in right eye, seizure disorder, and diabetes. On 4/18/13 at 2:29 PM, Client #2's discharge paperwork from her hospital admission between 3/5/13 and 3/19/13 was reviewed. The discharge paperwork indicated Client #2 was admitted to the hospital with respiratory distress, aspiration pneumonia, anemia, and shock liver (Ischemic Hepatitis-decreased blood supply to liver). The hospital discharge paperwork indicated Client #2 "presents with complaint of cough and congestion onset one day prior to admission. Caregiver per report also states that patient has not been wanting to eat for the past 2 days PTA (prior to admission). Patient having fever. Caregiver states the patient is nonverbal, but has been whining over the past 2 days. States patient is usually a very good eater, so it is abnormal for her to not want to eat. States patient's cough became worse today."			

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	On 4/19/13 at 3:25 PM, Client #2's physician orders for February, March, and April 2013 were received from Administrative staff #1. Client #2's MARs for February and April were received from Administrative staff #1. On 4/22/13 at 5:47 PM, Administrative staff #1 indicated no other physician orders or MARs were located for Client #2. Client #2's January 2013 physician orders and MAR and March 2013 MAR could not be located. No further documentation was presented. 2. The governing body failed to exercise general policy and operating direction over the facility to ensure the facility implemented its written policies and procedures to prevent neglect of client #3 in regard to aspiration pneumonia and falls. Please see W149. 3. The governing body failed to exercise general policy and operating direction over the facility to ensure the facility allowed clients #1 and #2 to participate in activities in the community. Please see W136. 4. The governing body failed to exercise general policy and operating direction over the facility to ensure the facility kept			

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	a complete accounting of the clients' finances as some financial records were not available to review for clients #1, #2, #3 and #4. Please see W140. 5. The governing body failed to exercise general policy and operating direction over the facility to ensure the facility informed client #3's guardian of the amount of funds in the client's savings account held by the facility, and/or to inform the client's guardian client #3 was not able to access her funds in the local savings account as the client did not have the required credentials/paper work. Please see W148. 6. The governing body failed to exercise general policy and operating direction over the facility to ensure the facility immediately reported an allegation of possible neglect to the administrator and/or failed to report an allegation of neglect to the Division of Disability, Aging and Rehabilitative Services (DDARS)/BDDS (Bureau of Developmental Disabilities Services) per 460 IAC 9-3-1 (b) (5) and to Adult Protective Services (APS) per IC 12-10-3 for client #3. Please see W153. 7. The governing body failed to exercise general policy and operating direction over the facility to ensure the facility took			

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	appropriate corrective measures and/or provided retraining in regard to an allegation of neglect involving client #3. Please see W157. 8. The governing body failed to exercise general policy and operating direction over the facility to ensure the facility's Health Care Services met the nursing needs of the client. The governing body failed to exercise general policy and operating direction over the facility to ensure the facility's Health Care Services developed risk plan in regard to the client's health, obtained clarification for monitoring residuals, monitored and/or assessed a client's "diaper rash," and to ensure clients' doctors were aware the clients' Medication Administration Records did not specify a specific time on when the clients' medications were to be administered to ensure the doctor agreed with the facility's practice. The governing body failed to exercise general policy and operating direction over the facility to ensure the facility's Health Care Services ensured ordered assessments were completed and a client's fall risk plan was updated for clients #1, #2, #3 and #4. Please see W331. 9. The governing body failed to exercise general policy and operating direction over the facility to ensure the facility's			

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	Health Care Services ensured staff were trained in regard to aspiration pneumonia, peg tube feedings and/or provided competency based training to ensure all staff understood and knew how to adequately perform peg tube feedings and care for client #3. Please see W342. 10. The governing body failed to exercise general policy and operating direction over the facility to ensure the facility's Health care Services ensured the facility administered all of client #2's medications during a medication pass. Please see W369. 9-3-1(a)			

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W000122	483.420 CLIENT PROTECTIONS The facility must ensure that specific client protections requirements are met. Based on observation, interview and record review, the facility failed to meet the Condition of Participation: Client Protections for 2 of 2 sampled clients (#1 and #2) and for 2 additional clients (#3 and #4). The facility failed to implement written policy and procedures to prevent neglect of client #3 in regard to the client's medical needs. The facility failed to ensure clients #1 and #2 participated in outings/activities in the community, to ensure the facility kept a complete accounting of client #1, #2, #3 and #4's monies, informed client #3's guardian of the client's savings account, to report all allegations of abuse/neglect to the administrator and/or to other officials per state law for client #3. The facility failed to ensure corrective measures were put in place to address issues found during an investigation of neglect to prevent recurrence for client #3. Findings include: 1. The facility failed to implement its written policies and procedures to prevent neglect of client #3 in regard to aspiration pneumonia and falls. Please see W149. 2. The facility failed to ensure clients #1	W000122	**Methods of ensuring client protections have been revised by 5/31/13.** Please see tags W149, W136, W140, W148, W157	05/31/2013

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	and #2 participated in activities in the community. Please see W136. 3. The facility failed to keep a complete accounting of the clients' finances as some financial records were not available to review for clients #1, #2, #3 and #4. Please see W140. 4. The facility failed to inform client #3's guardian of the amount of funds in the client's savings account held by the facility, and/or to inform the client's guardian client #3 was not able to access her funds in the local savings account as the client did not have the required credentials/paper work. Please see W148. 5. The facility failed to immediately report an allegation of possible neglect to the administrator and/or failed to report an allegation of neglect to the Division of Disability, Aging and Rehabilitative Services (DDARS)/BDDS (Bureau of Developmental Disabilities Services) per 460 IAC 9-3-1 (b) (5) and to Adult Protective Services (APS) per IC 12-10-3 for client #3. Please see W153. 6. The facility failed to take appropriate corrective measures and/or provide retraining in regard to an allegation of neglect involving client #3. Please see W157.			

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	9-3-2(a)			

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W000136	483.420(a)(11) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients have the opportunity to participate in social, religious, and community group activities. Based on interview and record review for 2 of 2 sampled clients (#1 and #2), the facility failed to ensure the clients participated in activities in the community. Findings include: Client #2's record was reviewed on 4/18/13 at 1:00 PM. Client #2's Daily Logs from February 2013 to April 2013 indicated client #2 had not participated in any community activities during the above mentioned time frame. Client #1's record was reviewed on 4/18/13 at 4:00 PM. Client #1's Daily Logs from February 2013 to April 2013 indicated client #1 had not participated in any community activities during the above mentioned time frame. Interview with staff #1 on 4/16/13 at 6:50 PM stated "It has been hard lately" to get clients out into the community. Staff #1 indicated 2 staff had 3 wheelchairs to maneuver. Staff #1 indicated client #2 did not go out often.	W000136	The Service Coordinator will retrain staff to ensure that all clients have the opportunity to go out into the community by 5/31/13. To ensure adherence to this training an activity log will be implemented at the home. This log will be sent to the service coordinator weekly for three months and then twice a month thereafter to ensure the clients continue to have regular community outings. The Behavior Health Director will monitor the Coordinators record monthly for three months and then periodically thereafter to ensure future compliance.	05/31/2013

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	15G559	A. BUILDING 00 B. WING	05/03/2013

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	Interview with Service Coordinator (SC) #1 and administrative staff #1 on 4/19/13 at 5:00 PM indicated the group home took clients #1 and #2 on outings in the community. SC #1 stated "Every weekend try to take out. Should be in weekend plans." Administrative staff #1 and/or SC #1 did not provide any additional information and/or documentation which indicated clients #1 and #2 participated in activities/outings in the community. 9-3-2(a)			

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W000140	483.420(b)(1)(i) CLIENT FINANCES The facility must establish and maintain a system that assures a full and complete accounting of clients' personal funds entrusted to the facility on behalf of clients. Based on record review and interview for 2 of 2 sampled clients (#1 and #2) and for 2 additional clients (#3 and #4), the facility failed to keep a complete accounting of the clients' finances as some financial records were not available to review. Findings include: Client #1's financial records were reviewed on 4/16/13 at 7:10 PM. Client #1's financial records indicated the client did not have "Budget Sheets" (financial sheets) in the home from April 2012 to December 2012 of the client's expenditures and/or deposits for the client's account kept at the group home. Client #1's financial records indicated the client also had a savings account, but the client's savings account book and/or records did not indicate the balance in the client's savings account. Client #2's financial records were reviewed on 4/16/13 at 7:10 PM. Client #2's financial records indicated the client did not have "Budget Sheets" (financial sheets) in the home from April 2012 to	W000140	A new procedure for maintaining client funds will be developed by 5/31/13. The Service Coordinator will train DSPs on this new system by 6/2/13. Staff will need to demonstrate how to fill out these budget forms and bank reconciliations. These documents will be reviewed by the service coordinator every two weeks and will be stored in a standardized location so that they are readily available. To ensure future compliance, The Service Coordinator will notify the staff and Area Manager if the client budget sheets and bank statements are not received the Monday after the budget period ends.	05/31/2013

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	December 2012 of the client's expenditures and/or deposits for the client's account kept at the group home. Client #2's financial records indicated the client also had a savings account, but the client's savings account book and/or records did not indicate the balance in the client's savings account. Client #3's financial records were reviewed on 4/16/13 at 7:10 PM. Client #3's financial records indicated the client did not have "Budget Sheets" (financial sheets) in the home from April 2012 to December 2012 of the client's expenditures and/or deposits for the client's account kept at the group home. Client #3's financial records indicated the client also had a savings account, but the client's savings account book and/or records did not indicate the balance in the client's savings account. Client #4's financial records were reviewed on 4/16/13 at 7:10 PM. Client #4's financial records indicated the client did not have "Budget Sheets" (financial sheets) in the home from April 2012 to December 2012 of the client's expenditures and/or deposits for the client's account kept at the group home. Client #4's financial records indicated the client also had a savings account, but the client's savings account book and/or			

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	records did not indicate the balance in the client's savings account. Client #1, #2, #3 and #4's financial records kept at the facility's office were reviewed on 4/19/13 at 2:53 PM. The financial records indicated the facility did not have budget sheets with receipts/expenditures for April 2012, May 2012, June 2012, July 2012, October 2012 and November 2012 for clients #1, #2, #3 and #4. Interview with staff #1 on 4/16/13 at 7:10 PM indicated clients #1, #2, #3 and #4 had no financial records/Budget Sheets for 2012 in the group home. Staff #1 indicated she had sent the sheets into the office. 9-3-2(a)			

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W000148	483.420(c)(6) COMMUNICATION WITH CLIENTS, PARENTS & The facility must notify promptly the client's parents or guardian of any significant incidents, or changes in the client's condition including, but not limited to, serious illness, accident, death, abuse, or unauthorized absence. Based on interview and record review for 1 additional client (#3), the facility failed to inform the client's guardian of the amount of funds in the client's savings account held by the facility, and/or to inform the client's guardian client #3 was not able to access her funds in the local savings account as the client did not have the required credentials/paper work. Findings include: Client #3's record was reviewed on 4/17/13 at 11:41 AM. Client #3's 8/16/12 Individual Support Plan (ISP) indicated client #3's brother was the client's guardian. Client #3's financial records were reviewed on 4/16/13 at 7:10 PM and on 4/19/13 at 2:53 PM. Client #3's 3/31/13 Statement of Account indicated client #3 had a savings account. The 3/31/13 statement indicated client #3 had a balance of $1,305.08. Interview with staff #1 on 4/16/13 at 7:10	W000148	The Service Coordinator obtained the clients valid state IDs by 5/31/13. This client's Guardian has been notified of the balance in her savings account. To ensure future compliance, the Behavioral Health Director will re-train all Service Coordinators on notifying Guardians of all changes in financial or medical condition by 5/31/13. The Service Coordinators will create a list of all clients and the dates in which their IDs expire to ensure they are renewed prior to expiration.	05/31/2013

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	PM indicated client #3's bank would no longer allow the group home to present a letter for the client to access her savings account at the bank. Staff #1 indicated the group home had been presenting the letter to get money out of the client's savings account. Staff #1 indicated client #3 was not able to sign her name. Staff #1 indicated client #3 did not have a valid state identification card to take to the bank to access her money. Staff #1 indicated the client's state identification card expired in 2007 when the client was at another group home. Staff #1 stated the Bureau of Motor Vehicles would not renew the client's state identification card as the group home "waited to late" to renew client #3's state identification card. Staff #1 indicated client #3 would have to present a birth certificate and social security card to the state agency to obtain a new identification card. Interview with client #3's guardian on 4/19/13 at 8:38 AM indicated he would forward client #3's social security check to the facility each month. When asked if the guardian was aware of client #3's savings account, the guardian stated "Not much in there." The guardian indicated client #3 did not make much at the workshop. 9-3-2(a)			

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W000149	483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on observation, record review and interview for 1 of 2 sampled clients (#3), the facility neglected to implement its written policies and procedures to prevent neglect of client #3 in regard to aspiration pneumonia and falls. Findings include: 1. The facility's reportable incident reports, internal Incident/Accident (I/A) Reports and/or investigations were reviewed on 4/16/13 at 2:29 PM. The facility's reportable incident reports, I/A reports and/or investigations indicated the following: -3/8/13 at 12:23 PM, "Staff noticed [client #3] has a cold and is breathing different (sic) today due to her nose being stopped up." The I/A "Action Taken" section indicated "It does seem that she has a cold and I did give her meds of nasal spray (saline) but it still seems that her nose is stuff (sic). I (day service Health & (and) Safety Technician) call (sic) the nurse to come over and assess." The I/A indicated the Health & Safety technician assessed the client on 3/8/13 at 12:55 PM and called the nurse on 3/8/13 at 12:10 PM	W000149	The Behavioral Health Director will review reporting and investigation requirements for Abuse, Neglect (including the neglect of medical care), Exploitation and injuries of unknown origin of clients with the Service Coordinator and DSPs that are involved with Beverly Dr by 5/31/13. In order to identify other areas of concern all other Coordinators will be trained on reporting and investigation requirements for Abuse, Neglect, and Exploitation. In order to prevent reoccurrences, posters explaining client rights and reporting requirements have been made and distributed to all group homes and the day program so that staff and clients become more aware of the requirements on an ongoing basis. Additionally, all staff will be trained on reporting and investigation requirements for Abuse Neglect, and Exploitation at least annually unless changes occur or need requires this to be done more frequently. To ensure that Service Coordinators are trained on reporting and investigation requirements for Abuse Neglect (including the neglect of medical care), Exploitation and injuries of unknown origin the Behavioral	05/31/2013

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	(sic). The 3/8/13 I/A did not indicate the facility's nurse assessed the client. -3/14/13 "The staff noticed when [client #3] came in she was shaking and not looking well and looking right. the (sic) staff notified the health tech (technician). The health tech took [client #3's] temperature which was a high temp (103.5) and immediately called the residential nurse. The health tech tried giving [client #3] crushed Tylenol (fever) with applesauce but she would not take it. 911 was called. The nurse took [client #3's] temperature which was 103.8. The nurse assessed [client #3] by checking her lungs which was (sic) clear and checking her abdomen which was soft. The EMT's (Emergency Medical Technicians) arrived and took [client #3] to [name of hospital]." The facility's 3/14/13 I/A Report indicated upon arrival to the day program, staff noticed a "change in physical condition/injuries..." with client #3. The facility's 3/14/13 Investigation Fact Sheet Summary and Conclusion indicated "Allegation: Possible Neglect-Consumer was transported to Day Services and appeared to be lethargic. Res (residential) staff reported that client was a little extra tired on Thursday morning. Staff had to		Health Director will review their training records at least annually and document review of findings. Area Managers will review DSP training records to ensure they have been training at least annually and document review of findings. All new Service Coordinators and DSPs will be trained on reporting and investigation requirements for Abuse Neglect (including the neglect of medical care), Exploitation and injuries of unknown origin prior to working a home or with a client. In addition, the Service Coordinators will be present in their homes at least two times per month to ensure protection of clients, address concerns, monitor activities, etc. Documentation of visits will be completed and will include specifics to the client as well as the visit. The Behavioral Health Director will review visitation logs weekly and once a pattern of regular visitation and observation is established reviews of visitation logs will fade to quarterly.	

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	wake client at least 4 times during breakfast. Res. morning staff got client ready for workshop-client took morning meds w/ (with) applesauce & took blood pressure 106/62. Staff fed client breakfast. Client ate about 3/4 of breakfast. Staff had to keep waking client up during breakfast. Staff reported that they were told by the previous nurse that client would have good days & bad days and some days would seem a little extra tired. Med driver picked client up and was told by staff that client did not eat all of her breakfast. Med driver stated, that client had no noticeable behaviors. During the past 3 days, Res staff noted-Monday client was alert & trying to feed self. Tuesday client was doing a lot of sleeping and had to wake client up to feed her. Wednesday client was feeding self with her hands for breakfast. Staff fed her dinner in the evening. She ate a lot of her dinner. Midnight staff noted that client did not wake up during the night. Nurse did not receive any phone calls/pages in the last 72 hours. Client did seem a little more tired per staff the morning of 3-14-13 but this is not out of the ordinary for client. Re (resident) staff was told by previous nurse that this is to be expected with client. Med driver did not notice any different behaviors from client the morning of 3-14-13." The 3/14/13 investigation indicated "...The			

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	allegation is not true...." The facility's recommendations indicated "No neglect by Day Service staff. Staff should return to work. Allegation not substantiated...." A 3/14/13 witness statement by staff #1 indicated she (staff #1) had told the med driver client #3 did not eat all her breakfast and that client #3 still had a cold. Staff #1's witness statement indicated staff #1 filled out a daily log "...and wrote that she (client #3) was still congested, even with taking the Sudafed (congestion) pills...On Monday [client #3] was alert and trying to feed herself...On Tuesday she was doing a lot of sleeping. I had to wake her to feed her...I was told by the nurse that had our house that [client #3] would have good days and bad days and that is to be expected with her illness." A 3/14/13 witness statement by staff #3 indicated the staff worked the overnight shift and checked on client #3 three different times on 3/14/13. The witness statement indicated client #3 slept through the night, and "...I (staff #3) noticed nothing unusual...." A 3/14/13 witness statement with the van driver indicated he transported client #3 to the workshop on 3/14/13. The van driver indicated "I was told that client did			

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	not eat much (per [staff #1]). No noticeable behavior. 9:45 [Name of Health Technician] asked why did I bring client in. Response Client did not eat much." A 3/14/13 witness statement by staff #4 indicated client #3 did not "look right" when the client came in to work on 3/14/13. The witness statement indicated client #3 was "...shaking like she was cold...." Staff #4's witness statement indicated "...This week I noticed she wasn't breathing right. I did incident report on it. The nurse from main came to look at her then they returned her back to the room...." A 3/14/13 witness statement with the health technician indicated she checked client #3 as staff had complained client #3 was shaking and cold. The witness statement indicated the temperature was 103.5 and she (the health tech) immediately called LPN #1 who "...said she 9:43 she going to a meeting (sic) & she would let [LPN #2] know (sic)...." The witness statement indicated the health tech then went to give the client crushed Tylenol in applesauce which client #3 did not take. The witness statement indicated she then had LPN #2 paged at 9:45 and told her "...to come right away cause [client #3] was real			

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	sick...." A 3/14/13 witness statement with [Service Coordinator] (SC) #3 indicated "Have not received any calls from group home regarding [client #3]. I did not know she had a cold until I received the logs from nurse...." A 3/15/13 witness statement by staff #2 indicated "...Wed (Wednesday) evening [client #3] seem (sic) to have a pretty decent evening however, she was a little tired. Most of the evening she sat up & before bedtime she spoke 2 to 3 words. She was very tired on Thursday morning. Once staff brought her out of her room, she seemed to be extra tired. Staff gave gave her meds & took her blood pressure. I don't remember the reading exactly but I do remember it was in the normal range...." The witness statement by staff #2 indicated a previous nurse had told them client #3 would "be tired off and on." A 3/15/13 witness statement by the Nurse Manager (NM) indicated she had been called by LPN #2 on 3/14/13 indicating client #3 "...was having the shakes & temp 103.4 & was going over to check her. Called me shortly after & said it was 103.8-very lethargic, unable to swallow Tylenol. To call 911. I told her to do a			

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	physical assessment-lungs, abd (abdomen)-if able before leaving to hosp (hospital) [LPN #2] later told me she checked her lungs x (times) 2 & they were clear. I had the nurse cell phone & did not receive any calls the last 12 hours." The facility's hand written undated investigative notes indicated "Res staff knew she had a cold, giving Sudafed-putting on logs...1 staff aware client had been congested earlier in week-No neglect-possible poor communication." The facility's 3/14/13 investigation/fact neglected to include any corrective measures in regard to improving communication. The facility's investigation also failed to address the facility's nursing services lack of assessment and/or follow-up in regard to the 3/8/13 daily log where it was indicated the client was having difficulty breathing. The facility's investigation also neglected to address the lack of reporting by facility staff to the nurse in regard to PRN usage. Client #3's hospital records were reviewed on 4/18/13 at 2:00 PM. Client #3's 3/14/13 ED (emergency department) notes indicated the chief complaints in the ER (emergency room) were the following: "-Fever			

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	-Shortness of Breath -Cyanosis (blue or purplish discoloration of skin) -Blood infection...She was sent here because of fever and low oxygenation. It is not known how long her symptoms have persisted...." The ED note indicated a physical was completed in the ER. The ED note indicated the following (not all inclusive): "B/P (blood pressure) 78/36/Pulse 79/ Temp(Src) 102.4 F (Fahrenheit) (39.1 C (Celsius) (Rectal)/ Resp (respirations) 14...SpO2 (room oxygen) 78%...." The ED note indicated client #3 was "Lethargic" and had "Mottled (patches of skin irregular in color) skin, cool extremities...." The 3/14/13 ED note indicated "Patient is here with hypotension and fever and clinically consistent with sepsis. We'll get labs, lactic acid and blood cultures. We'll give IV (intravenous) fluids and look for source...Pt (patient) has infiltrate on right side....also w/UTI (Urinary Tract Infection)....Dx (diagnosis) sepsis secondary to pneumonia, UTI." Client #3's ED note indicated client #3 was admitted to the hospital's Intensive Medical Care Unit. Client #3's 3/15/13 Infectious Disease Consult Note indicated client #3 had "Mild patchy pneumonia in the right mid			

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	lung field. There is also minimal pneumonia in bilateral hilar and perihilar regions in lung bases...development of pneumonia bilaterally...." The consult note indicated client #3 had bilateral pneumonia and aspiration pneumonia needed to be considered. The consult note indicated a swallowing evaluation was ordered. Client #3's 3/18/13 Clinical Swallow Study indicated "...Previous MBS (Modified Barium Swallow) was completed on 8/22/12 with recommendation for ground diet/mechanical soft (gravy to meats) and thin liquids." The study indicated client #3 was not able to follow directions...Nectar: Pharyngeal (slightly delayed cough after the swallow with a straw) Puree:..Pharyngeal: (intermittent and delayed cough after the swallow)...Recommend modified barium swallow to r/o (rule out) aspiration). Recommend keep NPO (nothing by mouth)...." Client #3's 3/19/13 SLP (Speech Language Pathologist) Modified Barium (Cookie) Swallow indicated "...Last swallow evaluation was a Clinical (Bedside) Swallow Evaluation 3/18/13 which revealed coughing after the swallow-suspicious for possible			

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	aspiration. Last known Modified Barium Swallow Study 8/22/12 revealed no aspiration or laryngeal penetration but revealed pharyngeal residue which patient reportedly cleared independently with via dry swallow." The MBS indicated client #3 was not able to follow commands. The MBS indicated the following (not all inclusive): "Consistencies Assessed: Thin...Pharyngeal: Delayed Swallow. Silent laryngeal penetration during the swallow. Nectar...Pharyngeal: Cough-Immediate due to patient's sensing pharyngeal residue after the swallow. Puree...Pharyngeal: Cough-Immediate due to patient sensing pharyngeal residue after the swallow. Solid...Pharyngeal: Cough-Immediate due to patient sensing pharyngeal residue after the swallow...." The 3/19/13 MBS indicated client #3 had "...Pharyngeal Dysphagia: Moderate Risk of Aspiration Secondary to:: (sic) Orally dysphagia, Pharyngeal dysphagia, and Cognition Compensatory Swallowing Strategies: Patient did not follow commands or compensatory techniques...Recommendations: Diet			

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	Recommendations NPO: Yes, due to patient's inability to use compensations for safety. Speech Therapy for swallowing not recommended due to patient's inability to follow commands for use of compensatory techniques for safety." A 3/20/13 Physician Progress Note indicated "...Patient's condition is guarded. Failed cookie swallow...Plan 1. For (sic) Peg (feeding tube)." Client #3's 3/21/13 Modified Barium (cookie) Swallow impression indicated "Impression: Episode of laryngeal penetration seen with thin liquid presented with sip cup. No aspiration seen. Rest of examination showed no laryngeal penetration or aspiration. Stasis in vallecula (chronic severe oropharynegeal (oral part of the airway) dysphagia) persist during the examination. Assessment/Plan:...Keep NPO (nothing by mouth) for now. Patient may be aspirating. Speech therapist evaluation noted...Patient failed cookie swallow. For PEG tomorrow." Client #3's 3/22/13 Gastroenterology progress note indicated a "Pre-procedure Diagnoses 1. Dysphagia [787.20] 2. Failure to thrive in adult [783.7]." Client #3's hospital records indicated nursing			

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	staff was monitoring for residuals while the client was in the hospital. Client 3's 3/27/13 Discharge Summary indicated client #3 was on bolus tube feedings. Client #3's discharge diagnoses included, but were not limited to, Sepsis, Bilateral Pneumonia...." The note indicated "Pt was started on IV antibiotics and IVF (intravenous infusion). She was very lethargic initially but soon became more with it. She however failed cookie swallow and had to get a peg tubeCXR (sic) (chest X-ray) done 22/ (sic) showed worsening pneumonia and pts (sic) was referred to LTAC (long term acute care) admission for continued IV antibiotics. Brother would not hear of that so her antibiotics was (sic) changed to po (by mouth) and py (unidentified) is going back to group home." Client #3's 3/28/13 Patient Demographics sheet indicated the client was discharged to the group home on 3/28/13. The demographics sheet indicated client #3's Final Diagnoses also included, but were not limited to, Septicemia (serious life threatening infection), Cyanosis, Dysphagia, Adult Failure to Thrive and Dehydration. Client #3's hospital records indicated the client was admitted for Septicemia, Pneumonia and Acute Respiratory Failure in 12/20/11 through 1/3/12.			

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	During the 4/16/13 observation period between 5:10 PM and 7:30 PM, at the group home, client #3 sat in a wheelchair. At 6:15 PM, staff #1 took client #3 to her bedroom to give her her medication via the peg tube and then to do the client's bolus feeding. Staff #1 placed a syringe into the peg tube to check for residual. The staff pulled the syringe to 30 and then stopped. Staff #1 then used a small amount of water to flush client #3's peg tube. Staff #1 poured client #3's dissolved medications into the syringe, flushed and poured 2 cans of Jevity, a little at a time, into the syringe. Staff #1 then flushed the peg tube, with the remainder, of the 300 cc of water after the feeding. Client #3's peg tube opening had gauze around the raw opening. Interview with staff #1 on 4/16/13 at 6:15 PM stated she was instructed to only "pull up halfway and stop." The syringe had cloudy liquid up to the 30 mark. Staff #1 indicated they did not measure residual amounts. Staff #1 stated they could feed the client as long as the liquid in the syringe did not have "Jevity (liquid food) color." Staff #1 indicated client #3's peg tube opening was cleaned every morning. Staff #1 stated "a little blood is ok. If smell or drainage changes color, call nurse." Staff #1 stated she used a "Q-tip" to clean around the opening. Staff #1 picked up a wash cloth which was on the			

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	dresser and said some staff used a wash cloth. Staff #1 stated the wash cloth was "abrasive." Client #3's record was reviewed on 4/17/13 at 11:41 AM. Client #3's Daily Logs indicated the following (not all inclusive): -3/4/13 "[Client #3] coughing & nose running. Robafen given @ (at) 5:48. Push fluids had to be fed by staff. Very large BM (bowel movement)." -3/5/12 BP (blood pressure) 100/68 P (pulse) 70 Nothing else documented on form. -3/12/13 BP 110/68 Nothing else documented on form. -3/13/13 BP 110/72 P 63 Nothing else documented on form. -3/14/13 BP 106/62 P 74 "She is still coughing and she sounds congestion (sic). We are still giving her Sudafed, had to wake her up at least four times this AM for breakfast." The daily log neglected to indicate the nurse was called in regard to the client's change in health status. Client #3's 3/1/13 to 3/31/13 Medication Administration Record (MAR) indicated			

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	client #3 received Saline Mist 1 spray in each nostril 4 times a day for congestion. Client #3's 3/13 MAR indicated client #3 had a PRN (as needed) for Pseudoephedrine (Sudafed) 30 milligrams 2 tablets orally every 4 hours as needed for nasal congestion. Client #3's MAR also indicated the client had a PRN order for Robitussin cough syrup 2 teaspoonfuls every 4 hours PRN for chest congestion or cough. Client #3's 3/13 MAR indicated the client received the following: -3/4/13 Robitussin cough syrup at supper and bedtime for cough. The back of the MAR where the PRN is documented with Reason & Result indicated the administration of the Robitussin was only documented once on 3/4/13. -3/6/13 Sudafed at bedtime for nasal congestion. -3/7/13 Sudafed in the morning (nasal congestion), at lunch and bedtime (coughing). The lunch dose was not documented on the back of the MAR. -3/8/13 Sudafed in the morning for coughing -3/9/13 Robitussin in the morning for cough.			

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-3/9/13 Sudafed at supper and bedtime for congestion. The back of the MAR indicated the nurse was called at 4:00 PM and told to give 2 tablets.

-3/10/13 Sudafed in the morning, lunch and bedtime for congestion.

-3/11/13 Sudafed in the morning and at bedtime for congestion. The back of the MAR indicated staff did not document the reason and result for the morning dose.

-3/12/13 Sudafed in the morning and at bedtime for congestion.

-3/14/13 Sudafed in the morning for congestion.

Client #3's 3/28/13 physician orders indicated client #3 received 5 cans of Jevity 1.2 daily. "Give 1 can @ 6a
give 2 cans @ 12p
give 2 cans at 6p. A 4/1/13 order indicated "Flush peg tube (with) 300 ml (milliliters) of water q (every) 6 hrs (hours)." Client #3's record and/or physician's order indicated the facility's nurse neglected to clarify/obtain an order regarding whether or not residuals should be checked/measured prior to feedings.

Client #3's Cumulative Medical Record

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	(doctor and nurse notes) indicated the following (not all inclusive): -2/20/12 Client #3 had an order to be evaluated for Hospice services. -2/21/12 Client #3 was accepted in to Hospice program. -8/14/12 "Cookie Swallow not done due to not wearing her harness. Will be rescheduled." -8/22/12 "Cookie Swallow test completed. Pt has no instance of Penetration or Aspiration. Complete report to follow." -2/12/13 ENT (Ears, Nose Throat) evaluation. The doctor recommended client #3 continue Saline Mist spray. -2/15/13 Client #3 went to her family doctor. Client #3's doctor indicated client #3's lungs were clear. -3/14/13 "Called to North workshop. [Client #3] temp 103.8. Slouched over in W/C (wheelchair). Appears pale & shaking. Very lethargic. Called 911. Lungs clear bilaterally, Abd soft, non-tender Bowel sounds present. Picked up by [name of company] ambulance. Transported to [name of hospital] ER			

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	(emergency room). -3/14/13 Admitted to [name of hospital] for observation & treatment." Client #3's Cumulative Medical record neglected to indicate the facility nurse assessed and/or documented her assessment of client #3 on 3/8/13 when the client was having difficulty breathing. The Cumulative Record and/or client #3's record neglected to indicate the facility staff informed the nurse of the above mentioned PRN usage with the client receiving Saline Nasal Spray 4 times a day. The facility's nursing services neglected to monitor client #3 and/or assess the client on 3/4/13 when the daily log was received, and/or assess the client on 3/9/13 when staff called the nurse about the client's congestion. The facility neglected to ensure a system was put in place which ensured the facility monitored PRN usage of clients to ensure assessments of clients' health were performed as needed. Client #3's 8/16/12 Medical Review Worksheet indicated client #3 was hospitalized on 12/21/11 for Pneumonia. The worksheet indicated "2 attempts @ cookie swallow 8/2 and 8/14 (2012)." Client #3's 3/7/12 Quarterly Nursing			

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	Assessment indicated client #3 was a hospice patient. Client #3's record did not indicate when client #3 stopped receiving Hospice services. Client #3's 8/11/11 typed letter from the client's neurologist indicated "The above patient (client #3) suffers from Down's Syndrome, autism, mental retardation and confusion which are all contributing factors for the diagnosis of Dementia...." Client #3's undated Caring For A J-tube And When To Call Your Nurse and/or 911 sheet indicated "[Name of another client not from this group home] has a Jejunostomy (J-tube) which is a procedure that creates a small opening through the outer stomach into the small intestines...1. Gather all supplies needed: medications, water, gloves, 30cc (cubic centimeter) med cup, pill crusher, syringe with bottle, etc...2. Universal precautions (wash hands before and after each task and water gloves) 3. Check the skin around the site for signs of infection. These may include: -Site is more tender and painful -Increased redness or swelling -Drainage that is green in color or foul smelling odor -Excessive leakage around the tube. **If staff notices any of the above signs of infection contact your nurse immediately.			

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	Make sure that you keep the skin around the tube clean and dry. Clean the skin around the site with plain water... If [name of other client] J-tube is pulled out CALL 911 IMMEDIATELY. **If J-tube becomes blocked or clogged and staff cannot unblock it call your nurse and the nurse will give staff further instructions...." At the top of the undated instruction sheet, a hand written statement indicated "Work Instructions for Peg & J tube feedings." An instruction sheet for giving Medications and Feedings with J-Tube or Peg Tube indicated "...2. Checking for placement of the J-tube or peg tube staff will need to place the stethoscope on the client stomach above the tubing, remove the knob from tubing and insert the syringe into the tubing use the bulb and slowly inject air into the tubing. Staff will hear a gurgling sound which will let you know the tubing is in the correct spot...." The instructions sheet indicated facility staff were to flush the tube with 30ml of warm tap water before all feedings or medications to ensure the peg tube was not clogged. The instruction sheet also indicated crushed pills were to be dissolved in 15cc of warm tap water and then flush with 15cc of warm tap water. The instruction sheet also indicated the peg tube was to be flushed			

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	with 30ml of warm tap water after each feeding. The above mentioned undated instruction sheets were located in a folder in client #3's bedroom for staff to refer to. Client #3's 8/16/12 Individual Support Plan (ISP) indicated the facility neglected to indicate client #3 had the diagnosis of Dementia. The ISP and/or record indicated the facility neglected to develop a care/risk plan for the client's Dementia and the client's decline in health. Client #3's record indicated the facility neglected to develop a risk plan for the client's aspiration/Dysphagia which included how the facility would monitor the client to prevent aspiration with a peg tube/feedings. Client #3's 8/16/12 ISP indicated the facility neglected to include a care/risk plan for the peg tube which was specific to client #3, reflected the client's current 4/1/13 physician's order for flushing (amount water ordered), how residuals were to be checked/monitored, and specifically indicated how the peg tube's opening was to be cleaned. Client #3's 8/16/12 ISP indicated the facility neglected to develop specific instructions in regard to how facility staff were to check for placement of the peg tube (if needed) and/or how staff should attempt to unblock a clogged tube. Client #3's ISP and/or record indicated the client's IDT (interdisciplinary team) had			

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	neglected to meet to review client #3's health status to ensure the client's health needs were addressed. The facility's time cards were reviewed on 4/17/13 at 2:00 PM. The facility's time cards/Residential Shifts Worked by Group Home indicated staff #7, #8 and #9 had worked at the group home since client #3 returned to the group home with a peg tube on 3/28/13. The facility's inservice/training records were reviewed on 4/16/13 at 11:47 AM. The facility's Individual Training/Group Training Report indicated the facility's nurse conducted an inservice on 3/28/13, with the staff at the group home, for 2 hours on "Feeding Tube." The inservice forms indicated LPN #1 conducted the training. The facility's Individual Training Reports indicated staff #7, #8 and #9 had not been trained in regard to client #3's feeding tubes/health needs. Staff #9's 3/28/13 Individual Training/Group Report indicated "[Client #3] not eating reg (regular) food, 5cc water for meds 60 water (sic) Must stay up 30 (degrees), Turn (sic) 2 hr., Change (sic) dressing every night. Call 911 if pull tub (sic) out." The form indicated "Were the materials provided effective? No." The 3/28/13 form indicated staff #10 documented "Not comfortable doing it."			

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	The form was signed by the staff's supervisor. The form neglected to indicate staff #10 was provided additional training to understand and/or perform the medical treatment/procedure to the best of her ability. Review of the 3/28/13 staff inservice forms indicated facility staff had been told to dissolve the client's medications in 5cc of water versus the 15cc of water as indicated by the undated instruction sheets. The facility's inservice/training record indicated day service program staff were trained in regard to client #3's feeding tube on 4/8/13 for 20 minutes by LPN #1. The 3/28/13 and 4/8/13 training reports neglected to indicate the nursing services conducted competency based training (monitored/checked off staff) to ensure each staff understood how to care for client #3's peg tube and/or do peg tube feedings. The facility's training reports also indicated the facility neglected to ensure facility staff were trained in regards to aspiration/aspiration pneumonia. Interview with staff #1 on 4/16/13 at 8:20 AM and at 5:55 PM indicated client #3 had not been feeling well for 2 weeks prior to hospitalization. Staff #1 indicated client #2 had pneumonia first and then client #3 got the pneumonia.			

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	15G559	A. BUILDING 00 B. WING	05/03/2013

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	Staff #1 indicated client #3 had a peg tube as client #3 did not do well on a cookie swallow test. Staff #1 indicated facility staff was trained in regard to client #3's peg tube feeding on 3/28/13. Interview with staff #6 on 4/16/13 at 3:50 PM indicated day service staff were trained in regard to client #3's feeding tube prior to the client's return to the day service program. When asked if the day service staff had been given risk plans since the placement of the peg tube, staff #6 indicated they had not received any risk plans from the group home. Interview with the Nurse Manager (NM) on 4/17/13 at 2:00 PM indicated she was not sure if staff were monitoring for residuals. The NM stated "I have not been in the group home." When asked what staff should do during a tube feeding, the NM stated "I don't know." Interview with the Nurse Manager (NM) and the Director of Health Care Services (DHCS), LPN #1, SC #1 and the Program Coordinator (PC) on 4/17/13 at 3:50 PM indicated client #3 had been on Hospice in the past. The NM indicated client #3 was on Hospice for Failure to Thrive, but had since been removed from Hospice Services. LPN #1 indicated client #3 was last hospitalized for Aspiration			

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	Pneumonia and returned to the group home on antibiotics. The NM indicated client #3's brother/guardian did not want client #3 to get the feeding tube. LPN #1 indicated client #3 received a Peg tube after the client failed a cookie swallow test. LPN #1 did not know if the client had a history of pneumonia/aspiration. When asked if facility staff should be monitoring for residuals, LPN #1 stated "Yes." LPN #1 stated the residual would be "cream color" when checking the residuals and the client still had food in her stomach. LPN #1 indicated facility staff should report residuals over 60 ml. LPN #1 and the DHCS stated using a wash cloth to clean the opening of the peg tube would be " harsh." LPN #1 indicated the facility staff received a memo to change the gauze dressing daily. When asked when facility staff first notified LPN #1 client #3 did not feel well, LPN #1 stated "Not sure." The DHCS, NM and LPN #1 indicated facility staff should have informed the nurse of the PRNs client #3 received. LPN #1 and the NM indicated facility staff and the day program staff had been trained in regard to client #3's peg tube. When asked if nursing staff had conducted competency training to ensure staff understood and/or fed the client correctly, LPN #1 indicated competency training had been conducted with staff #1 only. LPN #1 indicated no			

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	competency training had been done with the other staff in the group home and/or day program. When asked if staff had been trained in regard to aspiration pneumonia, LPN #1 stated "No." LPN #1 indicated the guidelines/instructions in place in regard to how to administer medications/feed the client were not specific in regard to how facility staff should clean the peg tube site. LPN #1 indicated client #3 did not have a risk plan for the Peg tube. When asked if client #3 had a risk plan for Dysphagia, LPN #1 stated "I believe so." The PC indicated client #3 had a Dysphagia plan in the past (2009). LPN #1 indicated client #1's instructions did not indicate what facility staff were to do if the peg tube opening was bleeding. The NM and the PC indicated client #3 was diagnosed with Dementia. L - PN #1 and the NM indicated client #3 did not have a risk plan for Dementia. The PC and SC indicated the IDT had not met in regard to client #3's health needs. Interview with client #3's guardian on 4/19/13 at 8:38 AM indicated client #3 was recently hospitalized for aspiration pneumonia and the client received a peg tube for feeding. Client #3's guardian indicated he did not want client #3 to have a peg tube, but was convinced by the hospital it was needed. Client #3's			

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	guardian stated "I wasn't going to do it. Not quality of life. I don't see her improving. I am going to get that thing removed when she passes cookie test." Client #3's guardian indicated client #3 had been hospitalized in the past for pneumonia. Client #3's guardian indicated with the previous hospitalization, they did not think client #3 would survive as the client was on life support with a breathing tube. Interview with the DHCS and LPN #1 on 4/19/13 at 1:35 PM indicated they did not know if client #3 was assessed by a nurse on 3/8/13 due to the client's difficulty in breathing. The DHCS and LPN #1 indicated an assessment should have been conducted and documented in the client's record. When asked if staff #6, #7 and #8 had been trained in regard to the Peg tube, LPN #1 indicated she had no additional training documentation. Interview with administrative staff #1 on 4/19/13 at 3:00 PM indicated the facility did not report the allegation of neglect (3/14/13 incident) to the Bureau of Developmental Disabilities Services. Administrative staff #1 indicated residential and day program staff were investigated and suspended. Administrative staff #1 stated they conducted an investigation to see "what			

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	happened and how." 2. The facility's reportable incident reports, internal Incident/Accident (I/A) Reports and/or investigations were reviewed on 4/16/13 at 2:29 PM. The facility's reportable incident reports, I/A Reports and/or investigations indicated the following: -8/12/12 at 3:45 AM, "Went to check on clients, [client #3] was on floor, has a small scrape on her right knee. Could not get her up by myself. Waited until second staff came in at 6 AM. Covered her up, put pillow under head." The I/A indicated the staff called the nurse, left a message on her phone and sent an e-mail. The I/A neglected to indicate any additional staff and/supervisors were called to come and assist in getting the client up off the floor. The I/A indicated the Service Coordinator did not review the incident report until 8/31/12. The I/A indicated the facility's nurse reviewed the incident report on 8/17/12 at 3:17 PM. The I/A indicated the nurse documented "Risk plan was followed." The facility's nurse neglected to report an allegation of possible neglect to the administrator in regard to staff #11 leaving the client on the floor from 3:45 AM to 6:00 AM. -8/16/12 at 8:00 PM, "Received a call			

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	from group home staff stating that [client #3] was sitting in her chair rocking herself as she normally does, and rocked herself to sleep, falling over sideways receiving a red mark on her forehead. Staff assisted [client #3] back to her sitting position and checked her for any injuries. No apparent injuries were found other than the small red area on forehead. Staff put pillows on her sides to prevent her from leaning over too far again. This was an isolated incident." -The facility's 8/16/12 I/A Report indicated client #3 fell "head first" to the floor. The facility's 8/21/12 follow-up report indicated "...There were no additional injuries incurred from this incident, and the red mark on her forehead is healed. [Client #3] did not fall back asleep after the incident. She was not in a rocking chair, she was in a regular arm chair. [Client #3] is autistic and rocks hard front to back in whatever chair she is seated in." During the 4/16/13 observation period between 5:10 PM and 7:30 PM at the group home, client #3 was in a wheelchair when she arrived at the group home. At 6:25 PM, staff #1 assisted client #3 to stand and pivot to sit on the			

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	couch. Client #3 was placed on the couch with little supports to keep the client upright. Staff #1 also placed a small stuffed animal in client #3's lap. Client #3's upper body started leaning forward. No staff was present in the living room to redirect the client to sit up. Client #3 had a pillow at her back and a pillow to each side of her which was uneven. The pillows did not provide support to sit upright. Client #3 sat with her head and upper body bent forward until the stuffed animal fell out of her lap to the floor. Client #3 then started to lean to her right side onto the pillow, still not in a safe sitting position. At 6:40 PM, the surveyor asked staff #1 if client #3 should be leaning while sitting on the couch, staff #1 returned to the living room and physically sat client #3 up straight. Staff #1 indicated client #3 would lean to the side and/or forward. During the 4/16/13 observation period between 5:38 AM and 8:45 AM, at the group home, client #3 utilized a wheelchair for mobility. Client #3 did not ambulate and/or use a gait belt. During the 4/16/13 observation period between 2:40 PM and 4:20 PM, at the facility's owned day program, client #3 remained in her wheelchair except to be toileted. Client #3 did not walk and/or			

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	utilize a gait belt. Client #3's record was reviewed on 4/17/13 at 11:41 AM. Client #3's 3/13/13 physician's order indicated the client's doctor ordered "OT/PT (Occupational Therapy/Physical Therapy) eval (evaluation/ w/ (with) chair assessment Dx (diagnoses Down Syndrome, Dementia." Client #3's Cumulative Medical Record notes and/or chart did not indicate client #3's OT/PT evaluations had been completed and/or set up. Client #3's 3/7/12 Quarterly Nursing Review indicated client #3 utilized a wheelchair for mobility. Client #3's 8/16/12 General Risk Factors Assessment indicated in the area of Physical Management, client #3 was "Unable to walk without verbal or greater assistance for any part of the day." The assessment indicated client #3 required the use of a gait belt when walking, and required "2 staff on either side." The assessment indicated client #3 had "One or more falls in the past 12 months." The 8/16/12 assessment indicated client #3 spent 2 or more hours a day in her wheelchair.			

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	Client #3's August 2012 Fall Risk Plan indicated the "Reason for the plan: Maintain health and safety by reducing number of falls...Client has a history of Grand Mal seizures, which could cause a fall. Client also walks with an unsteady gait. Baseline: Client uses a wheelchair for long distance; gait belt while walking." The fall prevention plan indicated "Staff need to monitor [client #3], at all times, when she is walking. Staff need to remind [client #3] to slow down whenever she is walking to (sic) fast...." Client #3's 8/12/12 ISP and/or 8/12 fall risk plan indicated the client's IDT neglected to meet, review and/or update client #3's fall risk plan as the client uses a wheelchair for mobility as the client's health has deteriorated. Interview with administrative staff #1 on 4/19/13 at 3:00 PM stated client #3 "used to walk and talk." Administrative staff #1 stated client #3 was "In decline." Administrative staff #1 stated client #3 "had been sick for a long time. Failure to thrive." Administrative staff #1 indicated the 8/12/12 incident was not immediately reported to the administrator. Interview with SC #1, the PC, LPN #1, the DHCS and the NM indicated client			

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	#3 used a wheelchair for ambulation. SC #1 stated the staff were trying "side by side to stand" with client #3. The NM indicated client #3 had an order to see the OT and PT in her chart. The NM indicated she did not know if the appointments had been scheduled as client #3's chart did not indicate the evaluations had been scheduled. SC #1, LPN #1, the DHCS and the NM did not not know if client #3 had a fall risk plan. The PC indicated client #3's fall risk plan would need to be revised as it indicates the client walks and utilizes a gait belt. The facility's policy and procedures were reviewed on 4/16/13 at 11:45 AM. The facility's 2/15/12 reviewed policy entitled Policy For Handling Cases Of Neglect And Abuse indicated "...1. The Arc Northwest Indiana prohibits all abuse, neglect and exploitation of our clients. II. Staff will immediately report any allegations if abuse, neglect or exploitation of out clients per agency reporting procedure. The Arc Northwest Indiana will meet current regulatory requirements for reporting all incidents. III. All allegations of abuse, neglect, humiliation or exploitation will be investigated per the Arc Northwest Indiana's investigation process, while protecting the individual...." The policy defined neglect "...as failure to consider			

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	and provide for the safety or care of the client and anticipate and remedy the placing of a client in a situation that poses a threat to his/her health and well being...." The policy indicated examples of neglect included, but were not limited to, depriving clients of medical care and treatment, not providing and "adequate personal care." 9-3-2(a)			

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W000153	483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. Based on interview and record review for 2 of 3 allegations of neglect and/or injuries of unknown source reviewed, the facility failed to immediately report an allegation of possible neglect to the administrator and/or failed to report an allegation of neglect to the Division of Disability, Aging and Rehabilitative Services (DDARS)/BDDS (Bureau of Developmental Disabilities Services) per 460 IAC 9-3-1 (b) (5) and to Adult Protective Services (APS) per IC 12-10-3 for client #3. Findings include: 1. The facility's reportable incident reports, internal Incident/Accident (I/A) Reports and/or investigations were reviewed on 4/16/13 at 2:29 PM. The facility's 3/14/13 reportable incident report indicated "The staff noticed when [client #3] came in she was shaking and not looking well and looking right. the (sic) staff notified the health tech (technician). The health tech took [client #3's] temperature which was a high temp	W000153	The Behavioral Health Director and/or Quality Systems Director will re-train Services Coordinators and Nurses on the procedure for reporting injuries of unknown origin and allegations of abuse/neglect to the administrator and BDDS by 5/31/13. To ensure future compliance, the Behavioral Health Director will review incident/accident reports to ensure that a BDDS report has been completed and the administrator has been notified for all injuries of unknown origin and allegations of abuse/neglect. In addition a team meeting will be held for all clients that are hospitalized with in 24 hrs of discharge to review treatment/risk plans and staff training. An investigation will be completed for all individuals whom are hospitalized for aspiration pneumonia. This investigation will not only review staffs actions, but all plans and treatments that had been in place to ensure that the facility's planning or lack of planning did not lead to the hospitalization. If neglect is suspected it will be reported, per reporting guidelines.	05/31/2013

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	(103.5) and immediately called the residential nurse. The health tech tried giving [client #3] crushed Tylenol (fever) with applesauce but she would not take it. 911 was called. The nurse took [client #3's] temperature which was 103.8. The nurse assessed [client #3] by checking her lungs which was (sic) clear and checking her abdomen which was soft. The EMT's (Emergency Medical Technicians) arrived and took [client #3] to [name of hospital]." The 3/14/13 reportable incident report indicated the facility did not report it was looking at neglect in regard to client #3's care. The facility's 3/14/13 Investigation Fact Sheet Summary and Conclusion indicated "Allegation: Possible Neglect-Consumer was transported to Day Services and appeared to be lethargic. Res (residential) staff reported that client was a little extra tired on Thursday morning. Staff had to wake client at least 4 times during breakfast. Res. morning staff got client ready for workshop-client took morning meds w/ (with) applesauce & took blood pressure 106/62. Staff fed client breakfast. Client ate about 3/4 of breakfast. Staff had to keep waking client up during breakfast. Staff reported that they were told by the previous nurse that client would have good days & bad days and some days would seem a little extra			

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	tired. Med driver picked client up and was told by staff that client did not eat all of her breakfast. Med driver stated, that client had no noticeable behaviors. During the past 3 days, Res staff noted-Monday client was alert & trying to feed self. Tuesday client was doing a lot of sleeping and had to wake client up to feed her. Wednesday client was feeding self with her hands for breakfast. Staff fed her dinner in the evening. She ate a lot of her dinner. Midnight staff noted that client did not wake up during the night. Nurse did not receive any phone calls/pages in the last 72 hours. Client did seem a little more tired per staff the morning of 3-14-13 but this is not out of the ordinary for client. Re (resident) staff was told by previous nurse that this is to be expected with client. Med driver did not notice any different behaviors from client the morning of 3-14-13." The 3/14/13 investigation indicated "...The allegation is not true...." The facility's recommendations indicated "No neglect by Day Service staff. Staff should return to work. Allegation not substantiated...." Interview with administrative staff #1 on 4/19/13 at 3:00 PM indicated the facility did not report the allegation of neglect (3/14/13 incident) to the Bureau of Developmental Disabilities Services.			

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	2. The facility's reportable incident reports, internal Incident/Accident (I/A) Reports and/or investigations were reviewed on 4/16/13 at 2:29 PM. The facility's reportable incident report dated 8/12/13 at 3:45 AM, indicated "Went to check on clients, [client #3] was on floor, has a small scrape on her right knee. Could not get her up by myself. Waited until second staff came in at 6 AM. Covered her up, put pillow under head." The I/A indicated the staff called the nurse, left a message on her phone and sent an e-mail. The I/A indicated the facility's nurse reviewed the incident report on 8/17/12 at 3:17 PM. The facility's nurse failed to report an allegation of possible neglect to the administrator in regard to staff #11 leaving the client on the floor from 3:45 AM to 6:00 AM. Interview with administrative staff #1 on 4/19/13 at 3:00 PM indicated the 8/12/12 incident was not immediately reported to the administrator. 9-3-2(a)			

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	15G559	A. BUILDING 00 B. WING	05/03/2013

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W000157	483.420(d)(4) STAFF TREATMENT OF CLIENTS If the alleged violation is verified, appropriate corrective action must be taken. Based on 1 of 3 allegations of neglect, abuse and/or injuries of unknown source reviewed, the facility failed to take appropriate corrective measures and/or provide retraining in regard to an allegation of neglect involving client #3. Findings include: The facility's reportable incident reports, internal Incident/Accident (I/A) Reports and/or investigations were reviewed on 4/16/13 at 2:29 PM. The facility's reportable incident reports, I/A reports and/or investigations indicated the following: -3/8/13 at 12:23 PM, "Staff noticed [client #3] has a cold and is breathing (sic) different today due to her nose being stopped up." The I/A "Action Taken" section indicated "It does seem that she has a cold and I did give her meds of nasal spray (saline) but it still seems that her nose is stuff (sic). I (day service Health & (and) Safety Technician) call the nurse to come over and assess." The I/A indicated the Health & Safety technician assessed the client on 3/8/13 at 12:55 PM and called the nurse on 3/8/13 at 12:10 PM (sic). The 3/8/13 I/A did not	W000157	Client #3 is discharged at this time. An investigation will be completed for all individuals whom are hospitalized for aspiration pneumonia. This investigation will not only review staffs actions, but all plans and treatments that had been in place plus the cause of the hospitalization to ensure that the facility's planning or lack of planning did not lead to the hospitalization. These plans will be corrected as necessary in order to prevent future neglectful situations. If neglect is suspected it will be reported, per reporting guidelines.	05/31/2013

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	indicate the facility's nurse assessed the client. -3/14/13 "The staff noticed when [client #3] came in she was shaking and not looking well and looking right. the (sic) staff notified the health tech (technician). The health tech took [client #3's] temperature which was a high temp (103.5) and immediately called the residential nurse. The health tech tried giving [client #3] crushed Tylenol (fever) with applesauce but she would not take it. 911 was called. The nurse took [client #3's] temperature which was 103.8. The nurse assessed [client #3] by checking her lungs which was (sic) clear and checking her abdomen which was soft. The EMT's (Emergency Medical Technicians) arrived and took [client #3] to [name of hospital]." The facility's 3/14/13 I/A Report indicated upon arrival to the day program, staff noticed a "change in physical condition/injuries..." with client #3. The facility's 3/14/13 Investigation Fact Sheet Summary and Conclusion indicated "Allegation: Possible Neglect-Consumer was transported to Day Services and appeared to be lethargic. Res (residential) staff reported that client was a little extra tired on Thursday morning. Staff had to			

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	wake client at least 4 times during breakfast. Res. morning staff got client ready for workshop-client took morning meds w/ (with) applesauce & took blood pressure 106/62. Staff fed client breakfast. Client ate about 3/4 of breakfast. Staff had to keep waking client up during breakfast. Staff reported that they were told by the previous nurse that client would have good days & bad days and some days would seem a little extra tired. Med driver picked client up and was told by staff that client did not eat all of her breakfast. Med driver stated, that client had no noticeable behaviors. During the past 3 days, Res staff noted-Monday client was alert & trying to feed self. Tuesday client was doing a lot of sleeping and had to wake client up to feed her. Wednesday client was feeding self with her hands for breakfast. Staff fed her dinner in the evening. She ate a lot of her dinner. Midnight staff noted that client did not wake up during the night. Nurse did not receive any phone calls/pages in the last 72 hours. Client did seem a little more tired per staff the morning of 3-14-13 but this is not out of the ordinary for client. Re (resident) staff was told by previous nurse that this is to be expected with client. Med driver did not notice any different behaviors from client the morning of 3-14-13." The 3/14/13 investigation indicated "...The			

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	allegation is not true...." The facility's recommendations indicated "No neglect by Day Service staff. Staff should return to work. Allegation not substantiated...." A 3/14/13 witness statement by staff #1 indicated she (staff #1) had told the med driver client #3 did not eat all her breakfast and that client #3 still had a cold. Staff #1's witness statement indicated staff #1 filled out a daily log "...and wrote that she (client #3) was still congested, even with taking the Sudafed (congestion) pills...On Monday [client #3] was alert and trying to feed herself...On Tuesday she was doing a lot of sleeping. I had to wake her to feed her...I was told by the nurse that had our house that [client #3] would have good days and bad days and that is to be expected with her illness." A 3/14/13 witness statement by staff #3 indicated the staff worked the overnight shift and checked on client #3 three different times on 3/14/13. The witness statement indicated client #3 slept through the night, and "...I (staff #3) noticed nothing unusual...." A 3/14/13 witness statement with the van driver indicated he transported client #3 to the workshop on 3/14/13. The van driver indicated "I was told that client did			

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	not eat much (per [staff #1]). No noticeable behavior. 9:45 [Name of Health Technician] asked why did I bring client in. Response Client did not eat much." A 3/14/13 witness statement by staff #4 indicated client #3 did not "look right" when the client came in to work on 3/14/13. The witness statement indicated client #3 was "...shaking like she was cold...." Staff #4's witness statement indicated "...This week I noticed she wasn't breathing right. I did incident report on it. The nurse from main came to look at her then they returned her back to the room...." A 3/14/13 witness statement with the health technician indicated she checked client #3 as staff had complained client #3 was shaking and cold. The witness statement indicated the temperature was 103.5 and she (the health tech) immediately called LPN #1 who "...said she 9:43 she going to a meeting (sic) & she would let [LPN #2] know (sic)...." The witness statement indicated the health tech then went to give the client crushed Tylenol in applesauce which client #3 did not take. The witness statement indicated she then had LPN #2 paged at 9:45 and told her "...to come right away cause [client #3] was real			

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	sick...." A 3/14/13 witness statement with [Service Coordinator] (SC) #3 indicated "Have not received any calls from group home regarding [client #3]. I did not know she had a cold until I received the logs from nurse...." A 3/15/13 witness statement by staff #2 indicated "...Wed (Wednesday) evening [client #3] seem to have a pretty decent evening however, she was a little tired. Most of the evening she sat up & before bedtime she spoke 2 to 3 words. She was very tired on Thursday morning. Once staff brought her out of her room, she seemed to be extra tired. Staff gave gave her meds & took her blood pressure. I don't remember the reading exactly but I do remember it was in the normal range...." The witness statement by staff #2 indicated a previous nurse had told them client #3 would "be tired off and on." A 3/15/13 witness statement by the Nurse Manager (NM) indicated she had been called by LPN #2 on 3/14/13 indicating client #3 "...was having the shakes & temp 103.4 & was going over to check her. Called me shortly after & said it was 103.8-very lethargic, unable to swallow Tylenol. To call 911. I told her to do a			

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	physical assessment-lungs, abd (abdomen)-if able before leaving to hosp (hospital) [LPN #2] later told me she checked her lungs x (times) 2 & they were clear. I had the nurse cell phone & did not receive any calls the last 12 hours." The facility's hand written undated investigative notes indicated "Res staff knew she had a cold, giving Sudafed-putting on logs...1 staff aware client had been congested earlier in week-No neglect-possible poor communication." The facility's 3/14/13 investigation/fact failed to include any corrective measures in regard to improving communication. The facility's investigation also failed to address the facility's nursing services lack of assessment and/or follow-up in regard to the 3/8/13 daily log where it was indicated the client was having difficulty breathing. The facility's investigation also failed to address and/or recommend any corrective measures/retraining for the lack of reporting by facility staff to the nurse in regard to PRN usage. Interview with administrative staff #1 on 4/19/13 at 3:00 PM indicated residential and day program staff were investigated and suspended. Administrative staff #1 stated they conducted an investigation to see "what happened and how."			

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	Administrative staff #1 did not indicate the facility retrained staff and/or put in place any corrective measures. 9-3-2(a)			

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W000159	483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. Based on interview and record review for 2 of 4 sampled clients (#1 and #2), the facility's Service Coordinator (SC) -Qualified Intellectual Disability Professional (QIDP) failed to ensure the guardian had given consent for a Behavior Support Plan for client #2. The QIDP failed to monitor client #1's objectives as no monthly summaries had been completed from 9/12 to 2/13. The QIDP failed to monitor client #1 in regard to assessments, and failed to address identified needs for clients #1 and #2. The QIDP failed to ensure facility staff implemented client #1's training objectives as outlined in the client's Individual Support Plan (ISP). Findings include: 1. On 4/18/13 at 1:00 PM, a record review for Client #2 indicated client #2's diagnoses included, but were not limited to, mental retardation, Down Syndrome, congenital blindness in right eye, seizure disorder, and diabetes. Client #2's Behavior Support Plan dated 10/12 indicated behaviors of throwing items,	W000159	A new QIDP is being trained to ensure a continuum of care Please see tags W210, W218, W220, W227, W242, W249, W255, W256, W257, W258	05/31/2013

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	hitting her head, and picking her skin. On 4/19/13 at 12:20 PM, Administrative staff #2 was interviewed and indicated the facility had no documentation of guardian consent for Client #2's Behavior Support Plan. Administrative staff #2 indicated it wasn't facility policy to secure guardian consent unless the Behavior Support Plan included restrictive practices. 2. The QIDP failed to re-assess client #1's wheelchair to ensure an appropriate fit and to re-assess client #2 in regard to declining mobility. Please see W210. 3. The QIDP failed to obtain a sensorimotor assessment as ordered for client #3. Please see W218. 4. The QIDP failed to assess client #1's communication skills. Please see W220. 5. The QIDP failed to include Physical Therapy recommendations in the Individual Service Plan for client #2. Please see W227. 6. The QIDP failed to address client #1's identified basic needs in regard to dressing and toileting. Please see W242. 7. The QIDP failed to ensure facility staff implemented client #1's training			

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	objectives when formal and/or informal opportunities existed. Please see W249. 8. The QIDP failed to monitor client #1's objectives to determine if the client's objectives were achieved. Please see W255. 9. The QIDP failed to monitor client #1's objectives to determine if the client had regressed and/or lost skills acquired. The QIDP also failed to revise a client's individual program plans as necessary to reflect situations in which the client is regressing as related to mobility for client #2. Please see W256. 10. The QIDP failed to monitor client #1's objectives to determine if the client failed to make progress after three months. Please see W257. 11. The QIDP failed to monitor client #1's objectives to determine if the client could be considered for training toward new objectives. Please see W258. 9-3-3(a)			

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W000210	483.440(c)(3) INDIVIDUAL PROGRAM PLAN Within 30 days after admission, the interdisciplinary team must perform accurate assessments or reassessments as needed to supplement the preliminary evaluation conducted prior to admission. Based on observation, interview and record review for 2 of 2 sampled clients (#1 and #2), the facility failed to re-assess client #1's wheelchair to ensure an appropriate fit and to re-assess client #2 in regard to declining mobility. Findings include: 1. During the 4/16/13 observation periods between 5:38 AM and 8:45 AM and from 5:10 PM to 7:30 PM, at the group home, client #1 utilized a custom wheelchair for mobility. Client #1's wheelchair's head rest was approximately 1 foot higher than the client's head as the client's head rested against the back of the wheelchair. A horizontal strap went across the client's chest and under/near the client's arm pits. Client #1's chest strap velcroed/fastened to the side of the client. Client #1's wheelchair had knee/leg straps/braces for each leg to keep them in position that were held together by velcro. Staff #1 placed the client's legs into the special straps/braces. Client #1 also had straps which went across the client's feet. During the 4/16/13	W000210	This client will have a wheelchair/PT evaluation completed by 5/31/13 To ensure future compliance, The IDT will review all PT/OT, audiological, nutritional, health, developmental and other assessments as they are received or at least annually to compare them to client goals and risk plans to ensure that all areas of need are being addressed. The Behavioral Health Director or designee will perform a random audit of client files at least quarterly to ensure that emerging client needs are being addressed by the team.	05/31/2013

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	observation period between 5:38 AM and 8:45 AM, client #1 removed herself from the chest strap by pulling on the velcro until it became loose and undone. The special straps/braces did not hold the client's spastic extremities as the client would move her legs until the velcro loosened and became undone. Client #1's foot straps became undone as well and the client had her feet off the foot rests. At one point during the observation period, client #1 was turned to the side in her wheelchair with one foot up in the seat of her wheelchair and the other leg/foot leaning to the side. Client #1's record was reviewed on 4/18/13 at 4:00 PM. Client #1's 9/19/12 Individual Support Plan and/or record did not indicate client #1 had a wheelchair assessment to ensure proper fitting. On 4/23/13 at 2:59 PM, the facility provided a 10/16/12 Delivery Ticket for a wheelchair for client #1. The delivery ticket indicated client #1 received her current custom wheelchair on 10/16/12 which cost $5,663.48. The sheet indicated client #1's wheelchair included a "knee blocker"/knee straps/brace. Interview with staff #1 and #2 on 4/16/13 at 4:20 PM indicated client #1's chest strap/harness did not fit the client			

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	properly. Staff #1 and #2 indicated the client had a different chest harness on her previous wheelchair. Staff #2 stated the client's current harness would fold up and did not look "comfortable" for the client as it laid across the client's breast. Staff #1 and #2 indicated client #1's head was below the head rest on the wheelchair. Interview with administrative staff #2 on 4/18/13 at 3:40 PM indicated they were not sure if client #1's wheelchair fitted her appropriately. Administrative staff #2 did not locate and/or provide documentation of a wheelchair evaluation for the client to ensure the client was appropriately evaluated. 2. During group home observations on 4/16/13 between 6:15 AM and 8:45 AM, Client #2 was observed sitting only in her wheelchair. Client #2 was observed in a non-customized wheelchair starting at 6:32 AM. Client #2 was wheeled up to a table in the living room and given her picture book to look through. At 6:47 AM, Client #2 was observed sleeping in her wheelchair. At 6:54 AM, Client #2 was interacting with her book again and then fell asleep until woken up by Service Coordinator #1 for medication at 7:08 AM. At 7:42 AM, Client #2 was brought to the kitchen table for breakfast and proceeded to eat breakfast while sitting in			

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	her wheelchair. At 8:32 AM, Client #2 was prompted to help put her arm through her coat in preparation of traveling to day service program. During day service program observation on 4/16/13, between 3:13 PM to 4:13 PM, at 3:13 PM, Client #2 was sitting in her wheelchair being fed a snack of applesauce with a spoon by Staff #4. When snack was complete, Staff #4 wheeled Client #2 over to a table. Client #2 was observed to remain in her wheelchair throughout the rest of day service observation. On 4/18/13 at 1:00 PM, a record review for Client #2 indicated Client #2's diagnoses included, but were not limited to, mental retardation, Down Syndrome, congenital blindness in right eye, seizure disorder, and diabetes. -An outpatient Physical Therapy (PT) evaluation dated 4/1/08 indicated Client #2 ambulated without assistive devices independently with a steady gait. The evaluation indicated Client #2's standing and walking dynamic balance were tested and graded "good." Client #2 was not at risk for falls. -A Physical Therapy (PT) evaluation dated 6/16/10 indicated Client #2 had			

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	15G559	A. BUILDING 00 B. WING	05/03/2013

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	standing tolerance for 5 seconds with a tendency to sit "suddenly." The evaluation indicated Client #2 required minimum assistance to transfer from a sitting position to a standing position and moderate assistance to transfer to bed. The evaluation indicated staff were instructed on the appropriate way to transfer and given home exercises for Client #2. The evaluation recommended to perform reevaluation if needed. -Client #2's Developmental Assessment dated 11/22/10 indicated Client #2 could not walk alone or go down stairs alone but had effective use of all her limbs except her left arm. The assessment indicated "however, the last several months has refused to help when standing, transferring, or toileting. She can stand without support for 5 minutes." -The Developmental Assessment dated 3/30/11 indicated Client #2 had poor body balance but could walk alone and walk down stairs by alternating feet. The assessment indicated Client #2 had effective use of all her limbs except her left arm. -The Medical Review Worksheet dated 12/5/11 indicated Client #2 had a wheelchair assessment on 12/30/10. The worksheet indicated a manual wheelchair			

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	was recommended for Client #2 for generalized muscle atrophy. -A Human Rights Committee - Survey of Rights for Client #2 dated 2/28/11 indicated a review of the use of "wheelchair for mobility" for Client #2. -The Developmental Assessment dated 2/12/12 indicated Client #2 had poor body balance and was unable to walk alone or walk down stairs by herself. The assessment indicated Client #2 had effective use of her right arm only. -Client #2's General Risk Factors Assessment dated 9/26/12 indicated Client #2 was "unable to walk alone," required use of a gait belt, required physical assistance for transfers, had one or more falls in past 12 months, one or more fractures in past 3 years, and spent 2 hours or more per day in a wheelchair. -Client #2's Individual Service Plan (ISP) dated 9/26/12 indicated the following goals: communication with pictures, cognitive activity, identifying needs, table setting, learning medications, washing face, toileting needs, and brushing teeth. -The Developmental Assessment dated 1/27/13 indicated Client #2 could stand without support for 5 minutes, had			

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	effective use of her right arm only but was beginning to help with transfers and walking from the wheelchair to the dining room table. During an interview on 4/18/13 at 2:21 PM, the Nurse Manager indicated Client #2's ISP did not include the PT recommended exercises or any range of motion exercises. Administrative staff #2 indicated Client #2's wheelchair assessment could not be located from 12/30/10. No documentation could be located indicating Client #2 had an updated PT evaluation since the 6/16/2010 PT evaluation. 9-3-4(a)			

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W000218	483.440(c)(3)(v) INDIVIDUAL PROGRAM PLAN The comprehensive functional assessment must include sensorimotor development. Based on observation, interview and record review for 1 additional client (#3), the facility failed to obtain a sensorimotor assessment as ordered. Findings include: The facility's reportable incident reports, internal Incident/Accident (I/A) Reports and/or investigations were reviewed on 4/16/13 at 2:29 PM. The facility's reportable incident reports, I/A Reports and/or investigations indicated the following: -8/12/12 at 3:45 AM, "Went to check on clients, [client #3] was on floor, has a small scrape on her right knee. Could not get her up by myself. Waited until second staff came in at 6 AM. Covered her up, put pillow under head." The I/A indicated the staff called the nurse, left a message on her phone and sent an e-mail. -8/16/12 at 8:00 PM, "Received a call from group home staff stating that [client #3] was sitting in her chair rocking herself as she normally does, and rocked herself to sleep, falling over sideways receiving a red mark on her forehead. Staff assisted [client #3] back to her sitting position and	W000218	This client will have a wheelchair/PT evaluation completed by 5/31/13 To ensure future compliance, The IDT will review all PT/OT, audiological, nutritional, health, developmental and other assessments as they are received or at least annually to compare them to client goals and risk plans to ensure that all areas of need are being addressed. The Behavioral Health Director or designee will perform a random audit of client files at least quarterly to ensure that emerging client needs are being addressed by the team.	05/31/2013

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	checked her for any injuries. No apparent injuries were found other than the small red area on forehead. Staff put pillows on her sides to prevent her from leaning over too far again...." -The facility's 8/16/12 I/A Report indicated client #3 fell "head first" to the floor. The facility's 8/21/12 follow-up report indicated "...There were no additional injuries incurred from this incident, and the red mark on her forehead is healed. [Client #3] did not fall back asleep after the incident. She was not in a rocking chair, she was in a regular arm chair. [Client #3] is autistic and rocks hard front to back in whatever chair she is seated in." During the 4/16/13 observation period between 5:10 PM and 7:30 PM at the group home, client #3 was in a wheelchair when she arrived at the group home. At 6:25 PM, staff #1 assisted client #3 to stand and pivot to sit on the couch. Client #3 was placed on the couch with little supports to keep the client upright. Staff #1 also placed a small stuffed animal in client #3's lap. Client #3's upper body started leaning forward. No staff was present in the living room to redirect the client to sit up. Client #3 had a pillow at			

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	her back and a pillow to each side of her which was uneven. The pillows did not provide support to sit upright. Client #3 sat with her head and upper body bent forward until the stuffed animal fell out of her lap to the floor. Client #3 then started to lean to her right side onto the pillow, still not in a safe sitting position. At 6:40 PM, the surveyor asked staff #1 if client #3 should be leaning while sitting on the couch, staff #1 returned to the living room and physically sat client #3 up straight. Staff #1 indicated client #3 would lean to the side and/or forward. During the 4/16/13 observation period between 5:38 AM and 8:45 AM, at the group home, client #3 utilized a wheelchair for mobility. Client #3 did not ambulate and/or use a gait belt. During the 4/16/13 observation period between 2:40 PM and 4:20 PM, at the facility's owned day program, client #3 remained in her wheelchair except to be toileted. Client #3 did not walk and/or utilize a gait belt. Client #3's record was reviewed on 4/17/13 at 11:41 AM. Client #3's 3/13/13 physician's order indicated the client's doctor ordered "OT/PT (Occupational Therapy/Physical Therapy) eval (evaluation/ w/ (with) chair assessment			

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	Dx (diagnoses Down Syndrome, Dementia." Client #3's Cumulative Medical Record notes and/or chart did not indicate client #3's OT/PT evaluations had not been completed and/or set up. Interview with administrative staff #1 on 4/19/13 at 3:00 PM stated client #3 "used to walk and talk." Administrative staff #1 stated client #3 was "In decline." Administrative staff #1 indicated client #3 "had been sick for a long time. Interview with SC #1, the PC, LPN #1, the DHCS and the NM indicated client #3 used a wheelchair for ambulation. SC #1 stated the staff were trying "side by side to stand" with client #3. The NM indicated client #3 had an order to see the OT and PT in her chart. The NM indicated she did not know if the appointments had been scheduled as client #3's chart did not indicate the evaluations had been scheduled. 9-3-4(a)			

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W000220	483.440(c)(3)(v) INDIVIDUAL PROGRAM PLAN The comprehensive functional assessment must include speech and language development. Based on observation, interview and record review for 1 of 2 sampled clients (#1), the facility failed to assess the client's communication skills. Findings include: During the 4/16/13 observation periods between 5:38 AM and 8:45 AM and from 5:10 PM to 7:30 PM, at the group home, client #1 was non-verbal in communication in that the client did not speak. Facility staff did not implement any communication training with the client and/or provide any assistive devices to assist client #1 to communicate her wants and needs. Client #1's record was reviewed on 4/18/13 at 4:00 PM. Client #1's 9/19/12 Individual Support Plan (ISP) and/or record indicated client #1 had the following objectives: - "[Client #1] will continue to learn to respond to her name." -"When given a choice of 2 items, [client #1] will reach for the one she wants." Client #1's 9/19/12 ISP and/or record did	W000220	This client will have a speech evaluation completed by 5/31/13 To ensure future compliance, The IDT will review all PT/OT, audiological, nutritional, health, developmental and other assessments as they are received or at least annually to compare them to client goals and risk plans to ensure that all areas of need are being addressed. The Behavioral Health Director or designee will perform a random audit of client files at least quarterly to ensure that emerging client needs are being addressed by the team.	05/31/2013

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	not indicate client #1's communication skills had been assessed. Client #1's ISP and/or record did not indicate the above mentioned objectives were recommended to assist the client to communicate her basic wants and needs. Interview with Service Coordinator (SC) #1 and administrative staff #1 on 4/19/13 at 5:00 PM indicated client #1 was non-verbal in communication. SC #1 indicated the above 2 mentioned training objectives were client #1's communication training objectives. When asked if client #1 had a recent speech/communication assessment, administrative staff #1 stated "Not one in 2 years." Administrative staff #1 could not locate a communication assessment for client #1. 9-3-4(a)			

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W000227	483.440(c)(4) INDIVIDUAL PROGRAM PLAN The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section. Based on observation, interview, and record review, the facility failed to include Physical Therapy recommendations in the Individual Service Plan for 1 of 4 sampled clients (Client #2). Findings include: During group home observations on 4/16/13 between 6:15 AM and 8:45 AM, Client #2 was observed sitting only in her wheelchair. Client #2 was observed in a non-customized wheelchair starting at 6:32 AM. Client #2 was wheeled up to a table in the living room and given her picture book to look through. At 6:47 AM, Client #2 was observed sleeping in her wheelchair. At 6:54 AM, Client #2 was interacting with her book again and then fell asleep until woken up by Service Coordinator #1 for medication at 7:08 AM. At 7:42 AM, Client #2 was brought to the kitchen table for breakfast and proceeded to eat breakfast while sitting in her wheelchair. At 8:32 AM, Client #2 was prompted to help put her arm through	W000227	The Service Coordinator and Individual Program Coordinator will review all ISPs to ensure they list and address through planning or programming all risks, PT/OT needs, speech needs, dietary needs, and behavioral needs. The ISP will list all adaptive equipment for the clients and will be made available to all staff working with that client by 5/31/13 To ensure future compliance, the Behavioral Health Director will audit IPP files following any change in client condition to ensure that the appropriate measures have been added to the ISP for three months and then periodically thereafter.	05/31/2013

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	her coat in preparation of traveling to day service program. During day service program observation on 4/16/13 between 3:13 PM to 4:13 PM, at 3:13 PM, Client #2 was sitting in her wheelchair being fed a snack of applesauce with a spoon by Staff #4. When snack was complete, Staff #4 wheeled Client #2 over to a table. Client #2 was observed to remain in her wheelchair throughout the day service observation. On 4/18/13 at 1:00 PM, a record review for Client #2 indicated client #2's diagnoses included, but were not limited to, mental retardation, Down Syndrome, congenital blindness in right eye, seizure disorder, and diabetes. -An outpatient Physical Therapy (PT) evaluation dated 4/1/08 indicated Client #2 ambulated without assistive devices independently with a steady gait. The evaluation indicated Client #2's standing and walking dynamic balance were tested and graded "good." Client #2 was not at risk for falls. -A Physical Therapy (PT) evaluation dated 6/16/10 indicated Client #2 had standing tolerance for 5 seconds with a tendency to sit "suddenly." The evaluation indicated Client #2 required minimum assistance to transfer from a			

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	sitting position to a standing position and moderate assistance to transfer to bed. The evaluation indicated staff were instructed on the appropriate way to transfer and given home exercises for Client #2. The evaluation recommended to perform reevaluation if needed. The PT evaluation recommended 6 exercises twice a day for Client #2 which included the following: Arm Chair Push, Sitting Heel Rise, Sitting Toe Raise, Long Arc Quads, Straight Leg Raises, and Bridging. -Client #2's Developmental Assessment dated 11/22/10 indicated Client #2 could not walk alone or go down stairs alone but had effective use of all her limbs except her left arm. The assessment indicated "however, the last several months has refused to help when standing, transferring, or toileting. She can stand without support for 5 minutes." -The Developmental Assessment dated 3/30/11 indicated Client #2 had poor body balance but could walk alone and walk down stairs by alternating feet. The assessment indicated Client #2 had effective use of all her limbs except her left arm. -The Medical Review Worksheet dated 12/5/11 indicated Client #2 had a wheelchair assessment on 12/30/10. The			

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	worksheet indicated a manual wheelchair was recommended for Client #2 for generalized muscle atrophy. -A Human Rights Committee - Survey of Rights for Client #2 dated 2/28/11 indicated a review of the use of "wheelchair for mobility" for Client #2. -The Developmental Assessment dated 2/12/12 indicated Client #2 had poor body balance and was unable to walk alone or walk down stairs by herself. The assessment indicated Client #2 had effective use of her right arm only. -Client #2's General Risk Factors Assessment dated 9/26/12 indicated Client #2 was "unable to walk alone," required use of gait belt, required physical assistance for transfers, had one or more falls in past 12 months, one or more fractures in past 3 years, and spent 2 hours or more per day in a wheelchair. -Client #2's Individual Service Plan (ISP) dated 9/26/12 indicated the following goals: communication with pictures, cognitive activity, identifying needs, table setting, learning medications, washing face, toileting needs, and brushing teeth. -The Developmental Assessment dated 1/27/13 indicated Client #2 could stand			

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	without support for 5 minutes, had effective use of her right arm only but was beginning to help with transfers and walking from the wheelchair to the dining room table. During an interview on 4/18/13 at 2:21 PM, the Nurse Manager indicated Client #2's ISP did not include the PT recommended exercises or any range of motion exercises. 9-3-4(a)			

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W000242	483.440(c)(6)(iii) INDIVIDUAL PROGRAM PLAN The individual program plan must include, for those clients who lack them, training in personal skills essential for privacy and independence (including, but not limited to, toilet training, personal hygiene, dental hygiene, self-feeding, bathing, dressing, grooming, and communication of basic needs), until it has been demonstrated that the client is developmentally incapable of acquiring them. Based on observation, interview and record review for 1 of 2 sampled clients (#1), the client's Individual Support Plan (ISP) failed to address the client's identified basic needs in regard to dressing and toileting. Findings include: During the 4/16/13 observation period between 5:38 AM and 8:45 AM, at the group home, client #1 required total staff assistance to get up and get dressed. Client #1's record was reviewed on 4/18/13 at 4:00 PM. Client #1's 9/19/12 ISP indicated "[Client #1] is currently receiving total assistance in all her daily living skills...." Client #1's 9/19/12 ISP indicated the client did not have training in place which addressed the client's basic needs in regard to toileting and dressing. Interview with staff #1 on 4/16/13 at 6:50	W000242	The Service Coordinator will review all client goals for this home to assess if goals address issues including, but not limited to, toilet training, personal hygiene, dental hygiene, self-feeding, bathing, dressing, grooming, and communication of basic needs. If current programming is deemed ineffective, it will be revised/modified with IDT/guardian approval or the individual will be evaluated to see if they are developmentally incapable of acquiring the skill and the goal will be discontinued by 5/31/13. To ensure future compliance, The IDT will review audiological, nutritional, health, developmental and other assessments as they are received, after any significant change in client condition, or at least annually to compare them to client goals and risk plans to ensure that all areas of need are being addressed. The Behavioral Health Director or designee will	05/31/2013

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	PM stated client #1 was "total care." Staff #1 indicated client #1 required total staff assistance in regard to bathing, dressing, toileting and tooth brushing. Staff #1 indicated client #1 did not have any training in place in regard to toileting and dressing. Interview with Service Coordinator #1 and administrative staff #1 on 4/19/13 at 5:00 PM indicated client #1 did not have any training in place which addressed the client's basic needs of dressing and toileting. 9-3-4(a)		monitor for completion by performing an audit on each file by 5/30/13. A random audit of client files will occur at least quarterly to ensure that emerging client needs are being addressed by the team.	

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W000249	483.440(d)(1) PROGRAM IMPLEMENTATION As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. Based on observation, interview and record review for 1 of 2 sampled clients (#1), the facility failed to implement the client's training objectives when formal and/or informal opportunities existed. Findings include: During the 4/16/13 observation periods between 5:38 AM and 8:45 AM and from 5:10 PM to 7:30 PM, at the group home, client #1 sat in her wheelchair moving her arms about spastically, sat without an activity and/or sat at a table without an activity except to be handed an item to hold and/or to place an item in front of the client. Client #1 did not pick up the item and/or dropped the items she was handed. During the morning observation, staff #1 wiped off client #1's face after she ate without encouraging the client to wipe her mouth with assistance. During the above mentioned observation periods, client #1 was non-verbal in communication in that the client did not speak. No communication training was	W000249	The Service Coordinator will review all client goals for this home to assess if goals address issues including, but not limited to, toilet training, personal hygiene, dental hygiene, self-feeding, bathing, dressing, grooming, and communication of basic needs. If current programming is deemed ineffective, it will be revised/modified with IDT/guardian approval or the individual will be evaluated to see if they are developmentally incapable of acquiring the skill and the goal will be discontinued by 5/31/13. Staff will be trained on implementing these goals by 5/31/13 it will be documented and return demonstration will occur as needed. To ensure future compliance, The IDT will review audiological, nutritional, health, developmental and other assessments as they are received, after any significant change in client condition, or at least annually to compare them to client goals and risk plans to ensure that all areas of need are being addressed. The Behavioral	05/31/2013

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	provided and/or offered to the client. Client #1's record was reviewed on 4/18/13 at 4:00 PM. Client #1's 9/19/12 Individual Support Plan (ISP) indicated client #1 had the following objectives: -Respond to her name -"When given a choice of 2 items, [client #1] will reach for the one she wants...." -When her name is called while she is involved in an activity, [client #1] will cease the activity...." -Wipe her spot at the table after dinner -"Before medication is administered, [client #1] will respond correctly (reach for medications)...." -Wash her face Facility staff during the 4/16/13 observation periods did not implement client #1's above mentioned ISP goals when formal and/or informal training opportunities existed. Interview with Service Coordinator (SC) #1 on 4/19/13 at 5:00 PM indicated facility staff should provide communication training with the client.		Health Director or designee will monitor for completion by performing an audit on each file by 5/30/13. A random audit of client files will occur at least quarterly to ensure that emerging client needs are being addressed by the team. **5/30/13**The Service Coordinator will review all client goals for this home to assess if goals address issues including, but not limited to, toilet training, personal hygiene, dental hygiene, self-feeding, bathing, dressing, grooming, and communication of basic needs. If current programming is deemed ineffective, it will be revised/modified with IDT/guardian approval or the individual will be evaluated to see if they are developmentally incapable of acquiring the skill and the goal will be discontinued by 5/31/13. Staff will be trained on implementing these goals by 5/31/13 it will be documented and return demonstration will occur as needed. Monitoring will occur on site as training opportunities are offered. To ensure future compliance, The IDT will review audiological, nutritional, health, developmental and other assessments as they are received, after any significant change in client condition, or at least annually to compare them to client goals and risk plans to ensure that all areas of need are being addressed. The Behavioral Health Director or designee will	

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	9-3-4(a)		monitor for completion by performing an audit on each file by 5/30/13. A random audit of client files will occur at least quarterly to ensure that emerging client needs are being addressed by the team.	

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W000255	483.440(f)(1)(i) PROGRAM MONITORING & CHANGE The individual program plan must be reviewed at least by the qualified mental retardation professional and revised as necessary, including, but not limited to situations in which the client has successfully completed an objective or objectives identified in the individual program plan. Based on interview and record review for 1 of 2 sampled clients (#1), the Qualified Intellectual Disability Professional (QIDP) failed to monitor client #1's objectives to determine if the client's objectives were achieved. Findings include: Client #1's record was reviewed on 4/17/13 at 11:41 AM. Client #1's 9/19/12 Individual Support Plan (ISP) indicated the client had the following objectives: - "[Client #1] will continue to learn to respond to her name by October 31, 2012." -"When given a choice of 2 items, [client #1] will reach for the one she wants for 5 of the last 10 sessions by October 31, 2012." -When her name is called while she is involved in an activity, [client #1] will cease the activity of 0 of the last 0	W000255	The Service Coordinator will monitor all clients' goal data and enter progress notes by 5/31/13. The Service Coordinator will then monitor goal data monthly and the IDT team will meet if any goals require modification. To ensure future compliance, the Behavioral Health Director will audit IPP files monthly to ensure that progress notes have been completed and client goals are being monitored for three months and periodically thereafter if the skill is acquired.	05/31/2013

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	sessions by October 31, 2012." -"[Client #1] will touch a block with a number on it for 5 of the last 10 periods by October 31, 2012." -"When done eating, [client #1] will wipe her spot at the table after dinner for 12 of the last 24 sessions by October 31, 2012." -"Before medication is administered, [client #1] will respond correctly with 50% independence for 10 of the last 10 sessions by October 31, 2012." -"When asked to do so, [client #1] will wash her face with 90% independence for 10 of the last 12 sessions by October 31, 2012." Client #1's 9/19/12 ISP indicated no monthly summary reviews had been completed of the above mentioned objectives to determine if the client had met the objectives since the 9/19/12 ISP was implemented. Interview with Service Coordinator (SC) #1/QIDP on 4/19/13 at 5:00 PM indicated she had taken over the group home as the new QIDP. SC #1 indicated she only had data for 3/13 to review. SC #1 did not provide any additional monitoring and/or monthly reviews of the client's objectives			

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	to determine if the client had met the ISP objectives. 9-3-4(a)			

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W000256	483.440(f)(1)(ii) PROGRAM MONITORING & CHANGE The individual program plan must be reviewed at least by the qualified mental retardation professional and revised as necessary, including, but not limited to situations in which the client is regressing or losing skills already gained. Based on interview and record review for 2 of 2 sampled clients (#1 and #2), the Qualified Intellectual Disability Professional (QIDP) failed to monitor client #1's objectives to determine if the client had regressed and/or lost skills acquired. The QIDP also failed to revise a client's individual program plan as necessary to reflect situations in which the client is regressing as related to mobility for client #2. Findings include: 1. Client #1's record was reviewed on 4/17/13 at 11:41 AM. Client #1's 9/19/12 Individual Support Plan (ISP) indicated the client had the following objectives: - "[Client #1] will continue to learn to respond to her name by October 31, 2012." -"When given a choice of 2 items, [client #1] will reach for the one she wants for 5 of the last 10 sessions by October 31, 2012."	W000256	The Service Coordinator will review all client goals including, but not limited to, toilet training, personal hygiene, dental hygiene, self-feeding, bathing, dressing, grooming, and communication of basic needs; for this home to assess if goals need to be added, modified, or discontinued by 5/31/13. The IDT will review audiological, nutritional, health, developmental and other assessments as they are received or at least annually to compare them to client goals and risk plans to ensure that all areas of need are being addressed. The Behavioral Health Director or designee will perform a random audit of client files at least quarterly to ensure that emerging client needs are being addressed by the team.	05/31/2013

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-When her name is called while she is involved in an activity, [client #1] will cease the activity of 0 of the last 0 sessions by October 31, 2012."

-"[Client #1] will touch a block with a number on it for 5 of the last 10 periods by October 31, 2012."

-"When done eating, [client #1] will wipe her spot at the table after dinner for 12 of the last 24 sessions by October 31, 2012."

-"Before medication is administered, [client #1] will respond correctly with 50% independence for 10 of the last 10 sessions by October 31, 2012."

-"When asked to do so, [client #1] will wash her face with 90% independence for 10 of the last 12 sessions by October 31, 2012."

Client #1's 9/19/12 ISP indicated no monthly summary reviews had been completed of the above mentioned objectives to determine if the client had met the objectives since the 9/19/12 ISP was implemented.

Interview with Service Coordinator (SC) #1/QIDP on 4/19/13 at 5:00 PM indicated she had taken over the group home as the

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	new QIDP. SC #1 indicated she only had data for 3/13 to review. SC #1 did not provide any additional monitoring and/or monthly reviews of the client's objectives to determine if the client had regressed and/or lost acquired skills. 2. On 4/18/13 at 1:00 PM, a record review for Client #2 indicated Client #2's diagnoses included, but were not limited to, mental retardation, Down Syndrome, congenital blindness in right eye, seizure disorder, and diabetes. -An outpatient Physical Therapy (PT) evaluation dated 4/1/08 indicated Client #2 ambulated without assistive devices independently with a steady gait. The evaluation indicated Client #2's standing and walking dynamic balance was tested and graded "good." Client #2 was not at risk for falls. -A Physical Therapy (PT) evaluation dated 6/16/10 indicated Client #2 had standing tolerance for 5 seconds with a tendency to sit "suddenly." The evaluation indicated Client #2 required minimum assistance to transfer from a sitting position to a standing position and moderate assistance to transfer to bed. The evaluation indicated staff were instructed on the appropriate way to transfer and given home exercises for			

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	Client #2. The evaluation recommended to perform reevaluation if needed. -Client #2's Developmental Assessment dated 11/22/10 indicated Client #2 could not walk alone or go down stairs alone but had effective use of all her limbs except her left arm. The assessment indicated "however, the last several months has refused to help when standing, transferring, or toileting. She can stand without support for 5 minutes." -The Developmental Assessment dated 3/30/11 indicated Client #2 had poor body balance but could walk alone and walk down stairs by alternating feet. The assessment indicated Client #2 had effective use of all her limbs except her left arm. -The Medical Review Worksheet dated 12/5/11 indicated Client #2 had a wheelchair assessment on 12/30/10. The worksheet indicated a manual wheelchair was recommended for Client #2 for generalized muscle atrophy. -A Human Rights Committee - Survey of Rights for Client #2 dated 2/28/11 indicated a review of the use of "wheelchair for mobility" for Client #2. -The Developmental Assessment dated			

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	2/12/12 indicated Client #2 had poor body balance and was unable to walk alone or walk down stairs by herself. The assessment indicated Client #2 had effective use of her right arm only. -Client #2's General Risk Factors Assessment dated 9/26/12 indicated Client #2 was "unable to walk alone", required use of gait belt, required physical assistance for transfers, had one or more falls in past 12 months, one or more fractures in past 3 years, and spent 2 hours or more per day in a wheelchair. -Client #2's Individual Service Plan (ISP) dated 9/26/12 indicated the following goals: communication with pictures, cognitive activity, identifying needs, table setting, learning medications, washing face, toileting needs, and brushing teeth. -The Developmental Assessment dated 1/27/13 indicated Client #2 could stand without support for 5 minutes, had effective use of her right arm only but was beginning to help with transfers and walking from the wheelchair to the dining room table. During group home observations on 4/16/13 between 6:15 AM and 8:45 AM, Client #2 was sitting only in her wheelchair. Client #2 was observed in a			

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	non-customized wheelchair starting at 6:32 AM. Client #2 was wheeled up to a table in the living room and given her picture book to look through. At 6:47 AM, Client #2 was observed sleeping in her wheelchair. At 6:54 AM, Client #2 was interacting with her book again and then fell asleep until woken up by Service Coordinator #1 for medication at 7:08 AM. At 7:42 AM, Client #2 was brought to the kitchen table for breakfast and proceeded to eat breakfast while sitting in her wheelchair. At 8:32 AM, Client #2 was prompted to help put her arm through her coat in preparation of traveling to day service program. During day service program observation on 4/16/13 between 3:13 PM to 4:13 PM, at 3:13 PM, Client #2 was sitting in her wheelchair being fed a snack of applesauce with a spoon by Staff #4. When snack was complete, Staff #4 wheeled Client #2 over to a table. Client #2 was observed to remain in her wheelchair throughout the day service observation. During an interview on 4/18/13 at 2:21 PM, the Nurse Manager indicated Client #2's ISP had not been revised to include the PT recommended exercises or any range of motion exercises. Administrative staff indicated Client #2's			

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	wheelchair assessment could not be located from 12/30/10. No documentation could be located indicating Client #2 had an updated PT evaluation since the 6/16/2010 PT evaluation. 9-3-4(a)			

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W000257	483.440(f)(1)(iii) PROGRAM MONITORING & CHANGE The individual program plan must be reviewed at least by the qualified mental retardation professional and revised as necessary, including, but not limited to situations in which the client is failing to progress toward identified objectives after reasonable efforts have been made. Based on interview and record review for 1 of 2 sampled clients (#1), the Qualified Intellectual Disability Professional (QIDP) failed to monitor client #1's objectives to determine if the client failed to make progress after three months. Findings include: Client #1's record was reviewed on 4/17/13 at 11:41 AM. Client #1's 9/19/12 Individual Support Plan (ISP) indicated the client had the following objectives: - "[Client #1] will continue to learn to respond to her name by October 31, 2012." -"When given a choice of 2 items, [client #1] will reach for the one she wants for 5 of the last 10 sessions by October 31, 2012." -When her name is called while she is involved in an activity, [client #1] will cease the activity of 0 of the last 0 sessions by October 31, 2012."	W000257	- The Service Coordinator will review all client goals for this home to assess if goals address issues including, but not limited to, toilet training, personal hygiene, dental hygiene, self-feeding, bathing, dressing, grooming, and communication of basic needs. If current programming is deemed, it will be revised/modified with IDT/guardian approval or the individual will be evaluated to see if they are developmentally incapable of acquiring the skill and the goal will be discontinued by 5/31/13. Staff will be trained on implementing these goals by 5/31/13. It will be documented and return demonstration will occur as needed. To ensure future compliance, The IDT will review audiological, nutritional, health, developmental and other assessments as they are received, after any significant change in client condition, or at least annually to compare them to client goals and risk plans to ensure that all areas of need are being addressed. The Behavioral Health Director or designee	05/31/2013

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	15G559	A. BUILDING 00 B. WING	05/03/2013

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	-"[Client #1] will touch a block with a number on it for 5 of the last 10 periods by October 31, 2012." -"When done eating, [client #1] will wipe her spot at the table after dinner for 12 of the last 24 sessions by October 31, 2012." -"Before medication is administered, [client #1] will respond correctly with 50% independence for 10 of the last 10 sessions by October 31, 2012." -"When asked to do so, [client #1] will wash her face with 90% independence for 10 of the last 12 sessions by October 31, 2012." Client #1's 9/19/12 ISP indicated no monthly summary reviews had been completed of the above mentioned objectives to determine if the client had met the objectives since the 9/19/12 ISP was implemented. Interview with Service Coordinator (SC) #1/QIDP on 4/19/13 at 5:00 PM indicated she had taken over the group home as the new QIDP. SC #1 indicated she only had data for 3/13 to review. SC #1 did not provide any additional monitoring and/or monthly reviews of the client's objectives to determine if the client had failed to		monitor for completion by performing an audit on each file by 5/30/13. A random audit of client files will occur at least quarterly to ensure that emerging client needs are being addressed by the team.	

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	make progress on the objectives after 3 months. 9-3-4(a)			

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W000258	483.440(f)(1)(iv) PROGRAM MONITORING & CHANGE The individual program plan must be reviewed at least by the qualified mental retardation professional and revised as necessary, including, but not limited to situations in which the client is being considered for training towards new objectives. Based on interview and record review for 1 of 2 sampled clients (#1), the Qualified Intellectual Disability Professional (QIDP) failed to monitor client #1's objectives to determine if the client could be considered for training toward new objectives. Findings include: Client #1's record was reviewed on 4/17/13 at 11:41 AM. Client #1's 9/19/12 Individual Support Plan (ISP) indicated the client had the following objectives: - "[Client #1] will continue to learn to respond to her name by October 31, 2012." -"When given a choice of 2 items, [client #1] will reach for the one she wants for 5 of the last 10 sessions by October 31, 2012." -When her name is called while she is involved in an activity, [client #1] will cease the activity of 0 of the last 0	W000258	The Service Coordinator will review all client goals for this home to assess if goals need to address issues including, but not limited to, toilet training, personal hygiene, dental hygiene, self-feeding, bathing, dressing, grooming, and communication of basic needs. If current programming is ineffective it will be revised/modified with IDT/guardian approval or the individual will be evaluated to see if they are developmentally incapable of acquiring the skill and the goal will be discontinued by 5/31/13. Staff will be trained on implementing these goals by 5/31/13. It will be documented and return demonstration will occur as needed. To ensure future compliance, The IDT will review audio logical, nutritional, health, developmental and other assessments as they are received, after any significant change in client condition, or at least annually to compare them to client goals and risk plans to ensure that all areas of need are being addressed. The Behavioral Health Director or designee will	05/31/2013

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	sessions by October 31, 2012." -"[Client #1] will touch a block with a number on it for 5 of the last 10 periods by October 31, 2012." -"When done eating, [client #1] will wipe her spot at the table after dinner for 12 of the last 24 sessions by October 31, 2012." -"Before medication is administered, [client #1] will respond correctly with 50% independence for 10 of the last 10 sessions by October 31, 2012." -"When asked to do so, [client #1] will wash her face with 90% independence for 10 of the last 12 sessions by October 31, 2012." Client #1's 9/19/12 ISP indicated no monthly summary reviews had been completed of the above mentioned objectives to determine if the client had met the objectives since the 9/19/12 ISP was implemented. Interview with Service Coordinator (SC) #1/QIDP on 4/19/13 at 5:00 PM indicated she had taken over the group home as the new QIDP. SC #1 indicated she only had data for 3/13 to review. SC #1 did not provide any additional monitoring and/or monthly reviews of the client's objectives		monitor for completion by performing an audit on each file by 5/30/13. A random audit of client files will occur at least quarterly to ensure that emerging client needs are being addressed by the team.	

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	to determine if the client had been considered for training toward new objectives. 9-3-4(a)			

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W000264	483.440(f)(3)(iii) PROGRAM MONITORING & CHANGE The committee should review, monitor and make suggestions to the facility about its practices and programs as they relate to drug usage, physical restraints, time-out rooms, application of painful or noxious stimuli, control of inappropriate behavior, protection of client rights and funds, and any other areas that the committee believes need to be addressed. Based on interview and record review, the facility failed to ensure the facility's HRC (Human Rights Committee) had given consent for restrictive practices in regards to use of anesthesia for routine medical examination for 1 of 3 sampled clients (Client #2). Findings include: On 4/18/13 at 1:00 PM, a record review for Client #2 indicated client #2's diagnoses included, but were not limited to, mental retardation, Down Syndrome, congenital blindness in right eye, seizure disorder, and diabetes. Review of Cumulative Medical Record indicated Client #2 had a pregnancy test draw for "preop" (pre-operative) on 11/12/12. The nurses note on 11/14/12 indicated Client #2 had a hospital gynecological examination and tolerated the procedure well.	W000264	The Service Coordinator will ensure that a desensitization plan is developed and staff are trained on this plan by 5/31/13 for all clients requiring anesthesia for medical or dental appointments. This plan will be reviewed and approved by the Guardian, IDT then HRC prior to the appointments. To ensure future compliance, The Behavioral Health Director and Service Coordinator will obtain HRC and Guardian approval for all use of drug usage, physical restraints, time-out rooms, application of painful or noxious stimuli, control of inappropriate behavior, or protection of client rights and funds.	05/31/2013

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	On 4/19/13 at 12:40 PM, the Nurse Manager was interviewed and indicated the facility is not involved in guardianship consent for procedures requiring anesthetic and believed it was the hospital's responsibility to obtain guardian consent. The Nurse Manager indicated there is no facility policy or practice to require Human Rights Committee or guardian consent for anesthesia given during routine medical examinations to control behavior. The Nurse Manager indicated no further documentation was available to indicate Human Rights Committee consent was given for Client #2's gynecological examination under general anesthesia on 11/14/12. 9-3-4(a)			

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W000318	483.460 HEALTH CARE SERVICES The facility must ensure that specific health care services requirements are met. Based on observation, interview and record review, the facility failed to meet the Condition of Participation: Health Care Services for 2 of 2 sampled clients (#1 and #2) and for 2 additional clients (#3 and #4). The facility's nursing services failed to meet the health care needs of the clients it served. The facility's health care services failed to assess, monitor and/or address clients' health care needs, and failed to ensure facility staff were trained to meet the health needs of clients #2 and #3. The facility's health care services failed to ensure all medications were administered without error for client #2. The facility's health care services failed to ensure the facility's practice in regard to times of medication administration was reviewed by client #1, #2 and #4's doctors. Findings include: 1. The facility's Health Care Services failed to ensure its nursing services met the nursing needs of the client. The facility's Health Care Services failed to ensure its nursing services developed risk plan in regard to the client's health, failed to obtain clarification for monitoring residuals, failed to monitor and/or assess	W000318	The methodology by which nursing services are being delivered has been changed please refer to tags W331, W342, W369	05/31/2013

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	a client's "diaper rash" and to ensure clients' doctors were aware the clients' Medication Administration Records did not specify a specific time on when the clients' medications were to be administered to ensure the doctor agreed with the facility's practice. The facility's Health Care Services failed to ensure its nursing services ensured ordered assessments were completed and a client's fall risk plan was updated for clients #1, #2, #3 and #4. Please see W331. 2. The facility's Health Care Services failed to ensure its nursing services ensured staff were trained in regard to aspiration pneumonia, peg tube feedings and/or provided competency based training to ensure all staff understood and knew how to adequately perform peg tube feedings and care for client #3. Please see W342. 3. The facility's Health care Services failed to ensure the facility administered all of client #2's medications during a medication pass. Please see W369. 9-3-6(a)			

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W000331	483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs. Based on observation, interview and record review for 2 of 2 sampled clients (#1 and #2)and for 2 additional clients (#3 and #4), the facility's nursing services failed to meet the nursing needs of the clients. The facility's nursing services failed to develop risk plan in regard to the client's health, failed to obtain clarification for monitoring residuals, failed to monitor and/or assess a client's "diaper rash" and to ensure clients' doctors were aware the clients' Medication Administration Records did not specify a specific time on when the clients' medications were to be administered to ensure the doctor agreed with the facility's practice. The facility's nursing services failed to ensure ordered assessments were completed and a client's fall risk plan was updated. Findings include: 1. The facility's reportable incident reports, internal Incident/Accident (I/A) Reports and/or investigations were reviewed on 4/16/13 at 2:29 PM. The facility's reportable incident reports, I/A reports and/or investigations indicated the following:	W000331	When a consumer is hospitalized the Community Services Nurse in coordination with the Service Coordinator will develop plans to address any changes in condition. A meeting will be held within 24 hours prior to or following discharge with the day program and others relevant to the client's care and document team discussion and approvals if necessary. To prevent reoccurrence, this will be done for all consumers returning home after hospitalization as a standard practice. The Medication Administration Schedule has been revised to reflect specific windows for administration. To ensure future compliance, The Behavioral Health Director or the Community Services Operations Director will hold a weekly meeting to review changes in client status and ensure these meetings are scheduled or have been completed and document this discussion.	05/24/2013

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	-3/8/13 at 12:23 PM, "Staff noticed [client #3] has a cold and is breathing different (sic) today due to her nose being stopped up." The I/A "Action Taken" section indicated "It does seem that she has a cold and I did give her meds of nasal spray (saline) but it still seems that her nose is stuff (sic). I (day service Health & (and) Safety Technician) call (sic) the nurse to come over and assess." The I/A indicated the Health & Safety technician assessed the client on 3/8/13 at 12:55 PM and called the nurse on 3/8/13 at 12:10 PM (sic). The 3/8/13 I/A did not indicate the facility's nurse assessed the client. -3/14/13 "The staff noticed when [client #3] came in she was shaking and not looking well and looking right. the (sic) staff notified the health tech (technician). The health tech took [client #3's] temperature which was a high temp (103.5) and immediately called the residential nurse. The health tech tried giving [client #3] crushed Tylenol (fever) with applesauce but she would not take it. 911 was called. The nurse took [client #3's] temperature which was 103.8. The nurse assessed [client #3] by checking her lungs which was (sic) clear and checking her abdomen which was soft. The EMT's (Emergency Medical Technicians) arrived and took [client #3] to [name of			

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	hospital]." The facility's 3/14/13 I/A Report indicated upon arrival to the day program, staff noticed a "change in physical condition/injuries..." with client #3. The facility's 3/14/13 Investigation Fact Sheet Summary and Conclusion indicated "Allegation: Possible Neglect-Consumer was transported to Day Services and appeared to be lethargic. Res (residential) staff reported that client was a little extra tired on Thursday morning. Staff had to wake client at least 4 times during breakfast. Res. morning staff got client ready for workshop-client took morning meds w/ (with) applesauce & took blood pressure 106/62. Staff fed client breakfast. Client ate about 3/4 of breakfast. Staff had to keep waking client up during breakfast. Staff reported that they were told by the previous nurse that client would have good days & bad days and some days would seem a little extra tired. Med driver picked client up and was told by staff that client did not eat all of her breakfast. Med driver stated, that client had no noticeable behaviors. During the past 3 days, Res staff noted-Monday client was alert & trying to feed self. Tuesday client was doing a lot of sleeping and had to wake client up to feed her. Wednesday client was feeding			

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	self with her hands for breakfast. Staff fed her dinner in the evening. She ate a lot of her dinner. Midnight staff noted that client did not wake up during the night. Nurse did not receive any phone calls/pages in the last 72 hours. Client did seem a little more tired per staff the morning of 3-14-13 but this is not out of the ordinary for client. Re (resident) staff was told by previous nurse that this is to be expected with client. Med driver did not notice any different behaviors from client the morning of 3-14-13." A 3/14/13 witness statement with the van driver indicated he transported client #3 to the workshop on 3/14/13. The van driver indicated "I was told that client did not eat much (per [staff #1]). No noticeable behavior. 9:45 [Name of Health Technician] asked why did I bring client in. Response Client did not eat much." A 3/14/13 witness statement by staff #4 indicated client #3 did not "look right" when the client came in to work on 3/14/13. The witness statement indicated client #3 was "...shaking like she was cold...." Staff #4's witness statement indicated "...This week I noticed she wasn't breathing right. I did incident report on it. The nurse from main came to look at her then they returned her back			

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	to the room...." A 3/14/13 witness statement with the health technician indicated she checked client #3 as staff had complained client #3 was shaking and cold. The witness statement indicated the temperature was 103.5 and she (the health tech) immediately called LPN #1 who "...said she 9:43 she going to a meeting & she would let [LPN #2] know (sic)...." The witness statement indicated the health tech then went to give the client crushed Tylenol in applesauce which client #3 did not take. The witness statement indicated she then had LPN #2 paged at 9:45 and told her "...to come right away cause [client #3] was real sick...." A 3/14/13 witness statement with [Service Coordinator] (SC) #3 indicated "Have not received any calls from group home regarding [client #3]. I did not know she had a cold until I received the logs from nurse...." A 3/15/13 witness statement by staff #2 indicated "...Wed (Wednesday) evening [client #3] seem (sic) to have a pretty decent evening however, she was a little tired. Most of the evening she sat up & before bedtime she spoke 2 to 3 words. She was very tired on Thursday morning. Once staff brought her out of her room,			

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	she seemed to be extra tired. Staff gave her meds & took her blood pressure. I don't remember the reading exactly but I do remember it was in the normal range...." The witness statement by staff #2 indicated a previous nurse had told them client #3 would "be tired off and on." A 3/15/13 witness statement by the Nurse Manager (NM) indicated she had been called by LPN #2 on 3/14/13 indicating client #3 "...was having the shakes & temp 103.4 & was going over to check her. Called me shortly after & said it was 103.8-very lethargic, unable to swallow Tylenol. To call 911. I told her to do a physical assessment-lungs, abd (abdomen)-if able before leaving to hosp (hospital) [LPN #2] later told me she checked her lungs x (times) 2 & they were clear. I had the nurse cell phone & did not receive any calls the last 12 hours." Client #3's hospital records were reviewed on 4/18/13 at 2:00 PM. Client #3's 3/14/13 ED (emergency department) notes indicated client #3's chief complaints in the ER (emergency room) were the following: "-Fever -Shortness of Breath -Cyanosis (blue or purplish discoloration			

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	of skin) -Blood infection...She was sent here because of fever and low oxygenation. It is not known how long her symptoms have persisted...." The ED note indicated a physical was completed in the ER. The ED note indicated the following (not all inclusive): "B/P (blood pressure) 78/36/Pulse 79/ Temp(Src) 102.4 F (Fahrenheit) (39.1 C (Celsius) (Rectal)/ Resp (respirations) 14...SpO2 (room oxygen) 78%...." The ED note indicated client #3 was "Lethargic" and had "Mottled (patches of skin irregular in color) skin, cool extremities...." The 3/14/13 ED note indicated "Patient is here with hypotension and fever and clinically consistent with sepsis. We'll get labs, lactic acid and blood cultures. We'll give IV (intravenous) fluids and look for source...Pt (patient) has infiltrate on right side....also w/UTI (Urinary Tract Infection)....Dx (diagnosis) sepsis secondary to pneumonia, UTI." Client #3's ED note indicated client #3 was admitted to the hospital's Intensive Medical Care Unit. Client #3's 3/15/13 Infectious Disease Consult Note indicated client #3 had "Mild patchy pneumonia in the right mid lung field. There is also minimal pneumonia in bilateral hilar and perihilar			

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	regions in lung bases...development of pneumonia bilaterally...." The consult note indicated client #3 had bilateral pneumonia and aspiration pneumonia needed to be considered. The consult note indicated a swallowing evaluation was ordered. Client #3's 3/18/13 Clinical Swallow Study indicated "...Previous MBS (Modified Barium Swallow) was completed on 8/22/12 with recommendation for ground diet/mechanical soft (gravy to meats) and thin liquids." The study indicated client #3 was not able to follow directions...Nectar: Pharyngeal (slightly delayed cough after the swallow with a straw) Puree:..Pharyngeal: (intermittent and delayed cough after the swallow)...Recommend modified barium swallow to r/o (rule out) aspiration). Recommend keep NPO (nothing by mouth)...." Client #3's 3/19/13 SLP (Speech Language Pathologist) Modified Barium (Cookie) Swallow indicated "...Last swallow evaluation was a Clinical (Bedside) Swallow Evaluation 3/18/13 which revealed coughing after the swallow-suspicious for possible aspiration. Last known Modified Barium Swallow Study 8/22/12 revealed no			

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	aspiration or laryngeal penetration but revealed pharyngeal residue which patient reportedly cleared independently with via dry swallow." The MBS indicated client #3 was not able to follow commands. The MBS indicated the following (not all inclusive): "Consistencies Assessed: Thin...Pharyngeal: Delayed Swallow. Silent laryngeal penetration during the swallow. Nectar...Pharyngeal: Cough-Immediate due to patient's sensing pharyngeal residue after the swallow. Puree...Pharyngeal: Cough-Immediate due to patient sensing pharyngeal residue after the swallow. Solid...Pharyngeal: Cough-Immediate due to patient sensing pharyngeal residue after the swallow...." The 3/19/13 MBS indicated client #3 had "...Pharyngeal Dysphagia: Moderate Risk of Aspiration Secondary to:: (sic) Orally dysphagia, Pharyngeal dysphagia, and Cognition Compensatory Swallowing Strategies: Patient did not follow commands or compensatory techniques...Recommendations: Diet Recommendations NPO: Yes, due to patient's inability to use compensations			

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	for safety. Speech Therapy for swallowing not recommended due to patient's inability to follow commands for use of compensatory techniques for safety." A 3/20/13 Physician Progress Note indicated "...Patient's condition is guarded. Failed cookie swallow...Plan 1.For (sic) Peg (feeding tube)." Client #3's 3/21/13 Modified Barium (cookie) Swallow impression indicated "Impression: Episode of laryngeal penetration seen with thin liquid presented with sip cup. No aspiration seen. Rest of examination showed no laryngeal penetration or aspiration. Stasis in vallecula (chronic severe oropharynegeal (oral part of the airway) dysphagia) persist during the examination. Assessment/Plan:...Keep NPO (nothing by mouth) for now. Patient may be aspirating. Speech therapist evaluation noted...Patient failed cookie swallow. For PEG tomorrow." Client #3's 3/22/13 Gastroenterology progress note indicated a "Pre-procedure Diagnoses 1. Dysphagia [787.20] 2. Failure to thrive in adult [783.7]." Client #3's hospital records indicated nursing staff was monitoring for residuals while the client was in the hospital.			

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	Client #3's 3/27/13 Discharge Summary indicated client #3 was on bolus tube feedings. Client #3's discharge diagnoses included, but were not limited to, Sepsis, Bilateral Pneumonia...." The note indicated "Pt was started on IV antibiotics and IVF (intravenous infusion). She was very lethargic initially but soon became more with it. She however failed cookie swallow and had to get a peg tubeCXR (sic) (chest X-ray) done 22/ (sic) showed worsening pneumonia and pts (sic) was referred to LTAC (long term acute care) admission for continued IV antibiotics. Brother would not hear of that so her antibiotics was (sic) changed to po (by mouth) and py (unidentified) is going back to group home." Client #3's 3/28/13 Patient Demographics sheet indicated the client was discharged to group home on 3/28/13. The demographics sheet indicated client #3's Final Diagnoses also included, but were not limited to, Septicemia (serious life threatening infection), Cyanosis, Dysphagia, Adult Failure to Thrive and Dehydration. Client #3's hospital records indicated the client was admitted for Septicemia, Pneumonia and Acute Respiratory Failure in 12/20/11 through 1/3/12. During the 4/16/13 observation period between 5:10 PM and 7;30 PM, at the			

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	group home, client #3 sat in a wheelchair. At 6:15 PM, staff #1 took client #3 to her bedroom to give her her medication via the peg tube and then to do the client's bolus feeding. Staff #1 placed a syringe into the peg tube to check for residual. The staff pulled the syringe to 30 and then stopped. Staff #1 then used a small amount of water to flush client #3's peg tube. Staff #1 poured client #3's dissolved medications into the syringe, flushed and poured 2 cans of Jevity, a little at a time, into the syringe. Staff #1 then flushed the peg tube, with the remainder, of the 300 cc of water after the feeding. Client #3's peg tube opening had gauze around the raw opening. Interview with staff #1 on 4/16/13 at 6:15 PM stated she was instructed to only "pull up halfway and stop." The syringe had cloudy liquid up to the 30 mark. Staff #1 indicated they did not measure residuals amounts. Staff #1 indicated they could feed the client as long as the liquid in the syringe did not have "Jevity (liquid food) color." Staff #1 indicated client #3's peg tube opening was cleaned every morning. Staff #1 stated "a little blood is ok. If smell or drainage changes color, call nurse." Staff #1 stated she used a "Q-tip" to clean around the opening. Staff #1 picked up a wash cloth which was on the dresser and said some staff used a wash cloth. Staff #1 stated the wash cloth was			

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	"abrasive." Client #3's record was reviewed on 4/17/13 at 11:41 AM. Client #3's Daily Logs indicated the following (not all inclusive): -3/4/13 "[Client #3] coughing & nose running. Robafen given @ (at) 5:48. Push fluids had to be fed by staff. Very large BM (bowel movement)." -3/5/12 BP (blood pressure) 100/68 P (pulse) 70 Nothing else documented on form. -3/12/13 BP 110/68 Nothing else documented on form. -3/13/13 BP 110/72 P 63 Nothing else documented on form. -3/14/13 BP 106/62 P 74 "She is still coughing and she sounds congestion (sic). We are still giving her Sudafed, had to wake her up at least four times this AM for breakfast." The daily log neglected to indicate the nurse was called in regard to the client's change in health status. Client #3's 3/1/13 to 3/31/13 Medication Administration Record (MAR) indicated client #3 received Saline Mist 1 spray in each nostril 4 times a day for congestion.			

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	Client #3's 3/13 MAR indicated client #3 had a PRN (as needed) for Pseudoephedrine (Sudafed) 30 milligrams 2 tablets orally every 4 hours as needed for nasal congestion. Client #3's MAR also indicated the client had a PRN order for Robitussin cough syrup 2 teaspoonfuls every 4 hours PRN for chest congestion or cough. Client #3's 3/13 MAR indicated the client received the following: -3/4/13 Robitussin cough syrup at supper and bedtime for cough. The back of the MAR where the PRN is documented with Reason & Result indicated the administration of the Robitussin was only documented once on 3/4/13. -3/6/13 Sudafed at bedtime for nasal congestion. -3/7/13 Sudafed in the morning (nasal congestion), at lunch and bedtime (coughing). The lunch dose was not documented on the back of the MAR. -3/8/13 Sudafed in the morning for coughing -3/9/13 Robitussin in the morning for cough. -3/9/13 Sudafed at supper and bedtime for			

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	congestion. The back of the MAR indicated the nurse was called at 4:00 PM and told to give 2 tablets. -3/10/13 Sudafed in the morning, lunch and bedtime for congestion. -3/11/13 Sudafed in the morning and at bedtime for congestion. The back of the MAR indicated staff did not document the reason and result for the morning dose. -3/12/13 Sudafed in the morning and at bedtime for congestion. -3/14/13 Sudafed in the morning for congestion. Client #3's 3/28/13 physician orders indicated client #3 received 5 cans of Jevity 1.2 daily. "Give 1 can @ 6a give 2 cans @ 12p give 2 cans at 6p. A 4/1/13 order indicated "Flush peg tube (with) 300 ml (milliliters) of water q (every) 6 hrs (hours). Client #3's record and/or physician's order indicated the facility's nurse did not clarify/obtain an order regarding whether or not residuals should be checked/measured prior to feedings. Client #3's Cumulative Medical Record (doctor and nurse notes) indicated the following (not all inclusive):			

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	-2/20/12 Client #3 had an order to be evaluated for Hospice services. -2/21/12 Client #3 was accepted in to Hospice program. -8/14/12 "Cookie Swallow not done due to not wearing her harness. Will be rescheduled." -8/22/12 "Cookie Swallow test completed. Pt has no instance of Penetration or Aspiration. Complete report to follow." -2/12/13 ENT (Ears, Nose Throat) evaluation The doctor recommended client #3 continue Saline Mist spray. -2/15/13 Client #3 went to her family doctor. Client #3's doctor indicated client #3's lungs were clear. -3/14/13 "Called to North workshop. [Client #3] temp 103.8. Slouched over in W/C (wheelchair). Appears pale & shaking. Very lethargic. called 911. Lungs clear bilaterally, Abd soft, non-tender Bowel sounds present. Picked up by [name of company] ambulance. Transported to [name of hospital] ER (emergency room).			

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	-3/14/13 Admitted to [name of hospital] for observation & treatment." Client #3's Cumulative Medical record failed to indicate the facility nurse assessed and/or documented her assessment of client #3 on 3/8/13 when the client was having difficulty breathing. The Cumulative Record and/or client #3's record failed to indicate the facility staff informed the nurse of the above mentioned PRN usage with the client receiving Saline Nasal Spray 4 times a day. The facility's nursing services failed to monitor client #3 and/or assess the client on 3/4/13 when the daily log was received, and/or assess the client on 3/9/13 when staff called the nurse about the client's congestion. The facility failed to ensure a system was in place which ensured the facility monitored PRN usage of clients to ensure assessments of clients' health as needed. Client #3's 8/16/12 Medical Review Worksheet indicated client #3 was hospitalized on 12/21/11 for Pneumonia. The worksheet indicated "2 attempts @ cookie swallow 8/2 and 8/14 (2012)." Client #3's 3/7/12 Quarterly Nursing Assessment indicated client #3 was a hospice patient. Client #3's record did not indicate when client #3 stopped receiving			

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	Hospice services. Client #3's 8/11/11 typed letter from the client's neurologist indicated "The above patient (client #3) suffers from Down's Syndrome, autism, mental retardation and confusion which are all contributing factors for the diagnosis of Dementia...." Client #3's undated Caring For A J-tube And When To Call Your Nurse and/or 911 sheet indicated "[Name of another client not from this group home] has a Jejunostomy (J-tube) which is a procedure that creates a small opening through the outer stomach into the small intestines...1. Gather all supplies needed: medications, water, gloves, 30cc (cubic centimeter) med cup, pill crusher, syringe with bottle, etc...2. Universal precaution (wash hands before and after each task and water gloves) 3. Check the skin around the site for signs of infection. These may include: -Site is more tender and painful -Increased redness or swelling -Drainage that is green in color or foul smelling odor -Excessive leakage around the tube. **If staff notices any of the above signs of infection contact your nurse immediately. **Make sure that you keep the skin around the tube clean and dry. Clean the skin around the site with plain water...**If [name of other client] J-tube is pulled out			

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	CALL 911 IMMEDIATELY. **If J-tube becomes blocked or clogged and staff cannot unblock it call your nurse and the nurse will give staff further instructions...." At the top of the undated instruction sheet, a hand written statement indicated "Work Instructions for Peg & J tube feedings." An instruction sheet for giving Medications and Feedings with J-Tube or Peg Tube indicated "...2. Checking for placement of the J-tube or peg tube staff will need to place the stethoscope on the client stomach above the tubing, remove the knob from tubing and insert the syringe into the tubing use the bulb and slowly inject air into the tubing. Staff will hear a gurgling sound which will let you know the tubing is in the correct spot...." The instructions sheet indicated facility staff were to flush the tube with 30ml of warm tap water before all feedings or medications to ensure the peg tube was not clogged. The instruction sheet also indicated crushed pills were to be dissolved in 15cc of warm tap water and then flush with 15cc of warm tap water. The instruction sheet also indicated the peg tube was to be flushed with 30ml of warm tap water after each feeding. The above mentioned undated instruction sheets were located in a folder in client #3's bedroom for staff to refer to.			

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	Client #3's 8/16/12 Individual Support Plan (ISP) indicated the facility's nursing services failed to indicate client #3 had the diagnosis of Dementia. The ISP and/or record indicated the facility's nursing services failed to develop a care/risk plan for the client's Dementia and the client's decline in health. Client #3's record indicated the facility failed to develop a risk plan for the client's aspiration/Dysphagia which included how the facility would monitor the client to prevent aspiration with a peg tube/feedings. Client #3's 8/16/12 ISP indicated the facility's nursing services failed to include a risk plan for the peg tube which was specific to client #3, reflected the client's current 4/1/13 physician's order for flushing (amount water ordered), how residuals were to be checked/monitored, and specifically indicated how the peg tube's opening was to be cleaned. Client #3's 8/16/12 ISP indicated the facility's nursing services failed to develop specific instructions in regard to how facility staff were to check for placement of the peg tube (if needed) and/or how staff should attempt to unblock a clogged tube. The facility's time cards were reviewed on 4/17/13 at 2:00 PM. The facility's time cards/Residential Shifts Worked by			

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	Group Home indicated staff #7, #8 and #9 had worked at the group home since client #3 returned to the group home with a peg tube on 3/28/13. The facility's inservice/training records were reviewed on 4/16/13 at 11:47 AM. The facility's Individual Training/Group Training Report indicated the facility's nurse conducted an inservice on 3/28/13, with the staff at the group home, for 2 hours on "Feeding Tube." The inservice forms indicated LPN #1 conducted the training. The facility's Individual Training Reports indicated staff #7, #8 and #9 had not been trained in regard to client #3's feeding tubes/health needs. Staff #9's 3/28/13 Individual Training/Group Report indicated "[Client #3] not eating reg (regular) food, 5cc water for meds 60 water (sic) Must stay up 30 (degrees), Turn (sic) 2 hr., Change (sic) dressing every night. Call 911 if pull tub (sic) out." The form indicated "Were the materials provided effective? No." The 3/28/13 form indicated staff #10 documented "Not comfortable doing it." The form was signed by the staff's supervisor. The form failed to indicate staff #10 was provided additional training to understand and/or perform the medical treatment/procedure to the best of her ability. Review of the 3/28/13 staff inservice forms indicated facility staff had			

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	been told to dissolve the client's medications in 5cc of water versus the 15cc of water as indicated by the undated instruction sheets. The facility's inservice/training record indicated day service program staff were trained in regard to client #3's feeding tube on 4/8/13 for 20 minutes by LPN #1. The 3/28/13 and 4/8/13 training reports neglected to indicate the nursing services conducted competency based training (monitored/checked off staff) to ensure each staff understood how to care for client #3's peg tube and/or do peg tube feedings. The facility's facility's training reports also indicated nursing services did not ensure facility staff were trained in regards to aspiration/aspiration pneumonia. Interview with staff #1 on 4/16/13 at 8:20 AM and at 5:55 PM indicated client #3 had not been feeling well for 2 weeks prior to hospitalization. Staff #1 indicated client #2 had pneumonia first and then client #3 got the pneumonia. Staff #1 indicated client #3 had a peg tube as client #3 did not do well on a cookie swallow test. Staff #1 indicated facility staff was trained in regard to client #3's peg tube feeding on 3/28/13. Interview with staff #6 on 4/16/13 at 3:50			

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	PM indicated day service staff were trained in regard to client #3's feeding tube prior to the client's return to the day service program. When asked if the day service staff had been given risk plans since the placement of the peg tube, staff #6 indicated they had not received any risk plans from the group home. Interview with the Nurse Manager (NM) on 4/17/13 at 2:00 PM indicated she was not sure if staff were monitoring for residuals. The NM stated "I have not been in the group home." When asked what staff should do during a tube feeding, the NM stated "I don't know." Interview with the Nurse Manager (NM) and the Director of Health Care Services (DHCS), LPN #1, SC #1 and the Program Coordinator (PC) on 4/17/13 at 3:50 PM indicated client #3 had been on Hospice in the past. The NM indicated client #3 was on Hospice for Failure to Thrive, but had since been removed from Hospice Services. LPN #1 indicated client #3 was last hospitalized for Aspiration Pneumonia and returned to the group home on antibiotics. The NM indicated client #3's brother/guardian did not want client #3 to get the feeding tube. LPN #1 indicated client #3 received a Peg tube after the client failed a cookie swallow test. LPN #1 did not know if the client			

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	had a history of pneumonia/aspiration. When asked if facility staff should be monitoring for residuals, LPN #1 stated "Yes." LPN #1 stated the residual would be "cream color" when checking the residuals and the client still had food in her stomach. LPN #1 indicated facility staff should report residuals over 60 ml. LPN #1 and the DHCS stated using a wash cloth to clean the opening of the peg tube would be " harsh." LPN #1 indicated the facility staff received a memo to change the gauze dressing daily. When asked when facility staff first notified LPN #1 client #3 did not feel well, LPN #1 stated "Not sure." The DHCS, NM and LPN #1 indicated facility staff should have informed the nurse of the PRNs client #3 received. LPN #1 and the NM indicated facility staff and the day program staff had been trained in regard to client #3's peg tube. When asked if nursing staff had conducted competency training to ensure staff understood and/or fed the client correctly, LPN #1 indicated competency training had been conducted with staff #1 only. LPN #1 indicated no competency training had been done with the other staff in the group home and/or day program. When asked if staff had been trained in regard to aspiration pneumonia, LPN #1 stated "No." LPN #1 indicated the guidelines/instructions in place in regard to how to administer			

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	medications/feed the client were not specific in regard to how facility staff should clean the peg tube site. LPN #1 indicated client #3 did not have a risk plan for the Peg tube. When asked if client #3 had a risk plan for Dysphagia, LPN #1 stated "I believe so." The PC indicated client #3 had a Dysphagia plan in the past (2009). LPN #1 indicated client #1's instructions did not indicate what facility staff were to do if the peg tube opening was bleeding. The NM and the PC indicated client #3 was diagnosed with Dementia. LPN #1 and the NM indicated client #3 did not have a risk plan for Dementia. Interview with client #3's guardian on 4/19/13 at 8:38 AM indicated client #3 was recently hospitalized for aspiration pneumonia and the client received a peg tube for feeding. Client #3's guardian indicated he did not want client #3 to have a peg tube, but was convinced by the hospital it was needed. Client #3's guardian stated "I wasn't going to do it. Not quality of life. I don't see her improving. I am going to get that thing removed when she passes cookie test." Client #3's guardian indicated client #3 had been hospitalized in the past for pneumonia. Client #3's guardian indicated with the previous hospitalization, they did not think client			

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#3 would survive as the client was on life support with a breathing tube.

Interview with the DHCS and LPN #1 on 4/19/13 at 1:35 PM indicated they did not know if client #3 was assessed by a nurse on 3/8/13 due to the client's difficulty in breathing. The DHCS and LPN #1 indicated an assessment should have been conducted and documented in the client's record. When asked if staff #6, #7 and #8 had been trained in regard to the Peg tube, LPN #1 indicated she had no additional training documentation.

2. The facility's reportable incident reports, internal Incident/Accident (I/A) Reports and/or investigations were reviewed on 4/16/13 at 2:29 PM. The facility's report -
able incident reports, I/A Reports and/or investigations indicated the following:

-8/12/12 at 3:45 AM, "Went to check on clients, [client #3] was on floor, has a small scrape on her right knee. Could not get her up by myself. Waited until second staff came in at 6 AM. Covered her up, put pillow under head." The I/A indicated the staff called the nurse, left a message on her phone and sent an e-mail.

-8/16/12 at 8:00 PM, "Received a call from group home staff stating that [client

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	#3] was sitting in her chair rocking herself as she normally does, and rocked herself to sleep, falling over sideways receiving a red mark on her forehead. Staff assisted [client #3] back to her sitting position and checked her for any injuries. No apparent injuries were found other than the small red area on forehead. Staff put pillows on her sides to prevent her from leaning over too far again. This was an isolated incident." -The facility's 8/16/12 I/A Report indicated client #3 fell "head first" to the floor. The facility's 8/21/12 follow-up report indicated "...There were no additional injuries incurred from this incident, and the red mark on her forehead is healed. [Client #3] did not fall back asleep after the incident. She was not in a rocking chair, she was in a regular arm chair. [Client #3] is autistic and rocks hard front to back in whatever chair she is seated in." During the 4/16/13 observation period between 5:10 PM and 7:30 PM at the group home, client #3 was in a wheelchair when she arrived at the group home. At 6:25 PM, staff #1 assisted client #3 to stand and pivot to sit on the couch. Client #3 was placed on the			

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	couch with little supports to keep the client upright. Staff #1 also placed a small stuffed animal in client #3's lap. Client #3's upper body started leaning forward. No staff was present in the living room to redirect the client to sit up. Client #3 had a pillow at her back and a pillow to each side of her which was uneven. The pillows did not provide support to sit upright. Client #3 sat with her head and upper body bent forward until the stuffed animal fell out of her lap to the floor. Client #3 then started to lean to her right side onto the pillow, still not in a safe sitting position. At 6:40 PM, the surveyor asked staff #1 if client #3 should be leaning while sitting on the couch, staff #1 returned to the living room and physically sat client #3 up straight. Staff #1 indicated client #3 would lean to the side and/or forward. During the 4/16/13 observation period between 5:8 AM and 8:45 AM, at the group home, client #3 utilized a wheelchair for mobility. Client #3 did not ambulate and/or use a gait belt. During the 4/16/13 observation period between 2:40 PM and 4:20 PM, at the facility's owned day program, client #3 remained in her wheelchair except to be toileted. Client #3 did not walk and/or utilize a gait belt.			

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Client #3's record was reviewed on 4/17/13 at 11:41 AM. Client #3's 3/13/13 physician's order indicated the client's doctor ordered "OT/PT (Occupational Therapy/Physical Therapy) eval (evaluation/ w/ (with) chair assessment Dx (diagnoses Down Syndrome, Dementia."

Client #3's Cumulative Medical Record notes and/or chart did not indicate client #3's OT/PT evaluations had been completed and/or set up.

Client #3's 3/7/12 Quarterly Nursing Review indicated client #3 utilized a wheelchair for mobility.

Client #3's 8/16/12 General Risk Factors Assessment indicated in the area of Physical Management, client #3 was "Unable to walk without verbal or greater assistance for any part of the day." The assessment indicated client #3 required the use of a gait belt when walking, and required "2 staff on either side." The assessment indicated client #3 had "One or more falls in the past 12 months." The 8/16/12 assessment indicated client #3 spent 2 or more hours a day in her wheelchair.

Client #3's August 2012 Fall Risk Plan

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	indicated the "Reason for the plan: Maintain health and safety by reducing number of falls...Client has a history of Grand Mal seizures, which could cause a fall. Client also walks with an unsteady gait. Baseline: Client uses a wheelchair for long distance; gait belt while walking." The fall prevention plan indicated "Staff need to monitor [client #3], at all times, when she is walking. Staff need to remind [client #3] to slow down whenever she is walking to (sic) fast...." Client #3's 8/12/12 ISP and/or 8/12 fall risk plan indicated the facility's nursing services failed to review and/or update client #3's fall risk plan as the client uses a wheelchair for mobility as the client's health has deteriorated. Interview with administrative staff #1 on 4/19/13 at 3:00 PM stated client #3 "used to walk and talk." Administrative staff #1 stated client #3 was "In decline." Administrative staff #1 stated client #3 "had been sick for a long time. Failure to thrive." Interview with SC #1, the PC, LPN #1, the DHCS, the NM indicated client #3 used a wheelchair for ambulation. SC #1 stated the staff were trying "side by side to stand" with client #3. The NM			

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	indicated client #3 had an order to see the OT and PT in her chart. The NM indicated she did not know if the appointments had been scheduled as client #3's chart did not indicate the evaluations had been scheduled. SC #1, LPN #1, the DHCS and the NM did not not know if client #3 had a fall risk plan. The PC indicated client #3's fall risk plan would need to be revised as it indicates the client walks and utilizes a gait belt. 3. The facility's reportable incident reports, internal Incident/Accident Report and/or investigations were reviewed on 4/16/13 at 2:29 PM. The facility's 3/6/13 I/A Report indicated "While changing [client #3], staff noticed a sore on [client #3's] upper right thigh, right where her depend sits at." The I/A indicated the Health & Safety Tech was informed of the area. The I/A indicated antibiotic ointment was applied to the area and staff were instructed to not let the elastic of the client's depend rub against the area. During the 4/16/13 observation periods between 5:38 AM and 8:45 AM and 5:10 PM to 7:30 PM, at the group home, client #3 used a wheelchair for mobility. Client #3 remained the majority of the observations in the wheelchair except during the 5:10 to 7:30 PM observation period when the client was placed on the			

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	couch in the living room. Client #3's record was reviewed on 4/17/13 at 11:41 AM. Client #3's April Medication Administration Record (MAR) indicated client #3 had a PRN for Desitin Powder for rash to be used as directed by the residential nurse with a referral to the physician if necessary. The 3/13 MAR indicated the Desitin was to be applied in the morning, lunch, supper and at bedtime. The 3/13 MAR indicated staff applied the Desitin to a rash on client #3's buttock for the following dates: -3/4/13 bedtime -3/5/13 bedtime -3/8/13 morning and at bedtime -3/9/13 morning, lunch, supper and bedtime -3/10/13 morning and lunch -3/11/13 morning, lunch, supper and bedtime -3/12/13 morning, supper and bedtime -3/30/13 morning, lunch, supper and bedtime			

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-3/31/13 at morning, lunch, supper and bedtime.

Client #3's 4/2013 MAR indicated Desitin has been applied daily since 4/1/13 to 4/18/13 3 to 4 times a day.

Client #3's Daily logs from 3/4/13 to 4/2/13 indicated the facility staff did not document anything in regard to the client's rash and/or skin breakdown when forwarding the daily logs to the nurse.

Client #3's Cumulative Medical records indicated indicated client #3 saw her primary care doctor on 4/8/13. The 4/8/13 note did not indicate the facility made the doctor aware of any skin issues and/or the use of the desitin PRN on a more regular basis. Client #3's Cumulative notes also did not indicate the facility staff made the nurse aware of the rash on the client's buttocks and/or have the nurse assess the rash as there was no documentation of the PRN usage and/or rash.

Client #3's 8/16/12 General Risk Factors Assessment indicated in the area of Physical Management, indicated client #3 spent 2 or more hours a day in her wheelchair. The risk assessment indicated client #3 had a repositioning

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	schedule. Client #3's 8/16/12 ISP indicated the client did not have a risk plan for skin integrity which included repositioning. Client #3's ISP did not indicate how client #3 was to be repositioned. Interview with SC #1, the NM and the DHCS on 4/17/13 at 3:50 PM indicated client #3 should be repositioned every 2 hours. SC #1 was not aware if client #3 had a skin integrity protocol/risk plan in place. Interview with LPN #1 on 4/19/13 at 3:25 PM indicated client #3 was to be repositioned every 2 hours. LPN #1 indicated she was not aware staff was applying Desitin to client #3's bottom. LPN #1 indicated she had not seen client #3's rash. LPN #1 indicated she was not sure client #1 had a risk plan in place for skin integrity. LPN #1 indicated the nurses and the SC were to develop the risk plans. LPN #1 indicated she did not have access to the risk plans. 4. During the 4/16/13 observation period between 5:38 AM and 8:45 AM, at the group home, clients #1, #2 and #4 received morning medications at the 7 AM medication pass. Client #2 received medications for			

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	seizures, blood pressure, potassium, supplements, hormones and etc. Client #1 received medications for spasticity, muscle spasms, Gastroesophageal Reflux, hormones, supplements, seizures, and etc. Client #4 received medications for allergies and eye drops. Review of client #1, #2, #4's 4/13 MARs on 4/16/13 at 8:45 AM indicated the facility did not designate a specific time when client #1, #2 and #4's medications were to be administered as the MARS only indicated Morning, Lunch, Supper and/or Bedtime. An undated typed medication schedule was reviewed on 4/15/13 at 6:25 PM. The undated paper indicated the following: AM (morning) medications could be administered between the hours of 5:00 AM and 11:59 AM Lunch medications could be administered between 12 noon and 2:00 PM Supper medications could be administered between 4:00 PM and 7:00 PM bedtime (HS) medications could be administered between 8:00 PM and 11:00 PM. Once daily medications should be administered in the AM "unless			

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	otherwise specified." Every 12 hours should be administered at 7:00 AM and 7:00 PM BID (Two times a day) AM and at supper in the evening TID (Three times a day) AM, lunch and bedtime Every 8 hours should be administered at 6:00 AM, 2:00 PM and 10:00 PM QID (Four times a day) AM, lunch, supper and bedtime. Client #2's record was reviewed on 4/18/13 at 1:00 PM. Client #2's physician's orders, Cumulative Medical Record and/or record did not indicate the client's physician was aware of the facility's medication administration practice. Client #1's record was reviewed on 4/18/13 at 4:00 PM. Client #1's physician's orders, Cumulative Medical Record and/or record did not indicate the clients' physician was aware of the facility's medication administration practice. Interview with the NM and DHCS on 4/16/13 at 1:00 PM indicated they were not aware of the above mentioned memo/typed note. The NM and the DHCS indicated they were not aware no medication times were on client #1, #2,			

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	#4's MARs for AM, lunch PM and HS. The DHCS indicated the MARs should have specific times. The NM indicated client #1, #2 and #4's doctor was not aware medications were not given at specific times (facility's medication administration practice). 5. On 4/16/13 at 11:49 AM, the facility BDDS (Bureau of Developmental Disabilities Services) reports were reviewed from 4/16/12 to 4/1/13. A BDDS report submitted 3/6/13 indicated Client #2 was assessed by the nurse due to symptoms of excess coughing. The report indicated Client #2 was congested and was sent to the emergency room. The report indicated Client #2 was admitted to the hospital with low oxygen levels and was receiving oxygen. On 4/18/13 at 1:00 PM, a record review for Client #2 indicated client #2's diagnoses included, but were not limited to, mental retardation, Down Syndrome, congenital blindness in right eye, seizure disorder, and diabetes. -The Individual Support Plan (ISP) for Client #2 dated 9/26/12 indicated risk plans for the following: seizure disorder, gastrointestinal bleeding and decreased endurance due to iron deficiency, diabetes, hyper or hypo glycemic reaction,			

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	impaired circulation related to fracture, heart attack or stroke due to hyperlipidemia, hypertension, and constipation. -A General Risk Factors Assessment dated 9/26/12 indicated in the Dysphagia section, Client #2 "is on or has been on modified food and/or fluid textures in past 12 months. Portion control, chopped." In the Dysphagia section of the assessment it is indicated if "any item is checked, complete 'Risk Assessment for Choking for Persons Who Eat By Mouth' and 'Assessment of Pneumonia Risk' and forward to Outreach." No further documentation of choking or pneumonia risk assessments could be located. -An Interdisciplinary Team meeting summary dated 9/26/12 indicated no additional risk plans for allergies and choking. -A choking risk plan for Client #2 dated April 2013 indicated Client #2 ate a pureed diet. The risk plan indicated staff should encourage Client #2 to slow down while eating and sit upright while swallowing and to bring her face closer to plate while eating. The risk plan indicated staff would know the symptoms of silent aspiration and know the signs of dysphasia. The plan indicated dysphasia			

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	could lead to aspiration pneumonia. The risk plan indicated staff "should call the nurse if [Client #2's] coughing/choking appears to be worsening." The plan indicated staff should document episodes of choking on the daily narrative and an incident report should be filled out if staff needed to physically assist Client #2 during a coughing or choking episode. On 4/18/13 at 2:29 PM, Client #2's discharge paperwork from her hospital admission between 3/5/13 and 3/19/13 was reviewed. The hospital discharge paperwork indicated Client #2 "presents with complaint of cough and congestion onset one day prior to admission. Caregiver per report also states that patient has not been wanting to eat for the past 2 days PTA [prior to admission]. Patient having fever. Caregiver states the patient is nonverbal, but has been whining over the past 2 days. States patient is usually a very good eater, so it is abnormal for her to not want to eat. States patient's cough became worse today." The discharge paperwork indicated Client #2 was admitted to the hospital with respiratory distress, aspiration pneumonia, anemia, and shock liver (Ischemic Hepatitis-decreased blood supply to liver). -A hospital swallow evaluation dated			

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	3/18/13 indicated a recommended change in diet from chopped to puree diet with extra gravy, nectar thickened liquids, and small sips and bites only. During an observation at Client #2's day service program on 4/16/13 at 4:00 PM, Staff #4 indicated she was not trained on any choking, aspiration, or pneumonia risk plans for Client #2. Staff #4 indicated Client #2 had risk plans in the day service program for iron deficiency, cataracts, fall risk, constipation, and impaired circulation related to fracture. Staff #4 indicated there was no direct communication between the group home and the day service staff. Staff #4 indicated the nurse would inform them of any client health concerns. Staff #4 indicated she was unaware why Client #2 was admitted to the hospital and had a diet change to puree. Staff #4 indicated the facility would not inform her of the cause of Client #2's hospital stay. Staff #4 indicated she was told it was a HIPAA (Health Insurance Portability and Accountability Act) violation to inform her of Client #2's hospital information. During an interview on 4/18/13 at 4:30 PM, the Nurse Manager indicated facility policy was staff could give PRN (given as needed) medication without checking vitals and without notifying nursing staff.			

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	LPN #1 indicated staff had not been trained on identifying the signs and symptoms of aspiration pneumonia when she returned from the hospital. The Nurse Manager indicated no additional care plan for aspiration pneumonia had been developed when Client #2 returned from the hospital. 9-3-6(a)			

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W000342	483.460(c)(5)(iii) NURSING SERVICES Nursing services must include implementing with other members of the interdisciplinary team, appropriate protective and preventive health measures that include, but are not limited to training direct care staff in detecting signs and symptoms of illness or dysfunction, first aid for accidents or illness, and basic skills required to meet the health needs of the clients. Based on observation, interview and record review for 1 additional client (#3), the facility's nursing services failed to ensure staff were trained in regard to aspiration pneumonia, peg tube feedings and/or provided competency based training to ensure all staff understood and knew how to adequately perform peg tube feedings and care. Findings include: The facility's reportable incident reports, internal Incident/Accident (I/A) Reports and/or investigations were reviewed on 4/16/13 at 2:29 PM. The facility's reportable incident reports, I/A reports and/or investigations indicated the following: -3/8/13 at 12:23 PM, "Staff noticed [client #3] has a cold and is breathing different (sic) today due to her nose being stopped up." The I/A "Action Taken" section indicated "It does seem that she has a cold	W000342	Client # 3 has been discharged from the program. Since discharge her peg tube has been discontinued. If she is able to return to the program or other consumers require a peg tube or other medical devices, a risk plan providing instruction for care will be developed and the Community Services Nurse will train and monitor staff on the peg tube for care, cleaning, and feeding daily until such time staff demonstrate competency with the peg tube or other medical devices. Training will involve modeling and return demonstrations will be documented. Nurse monitoring will decrease according to staff competency and monthly thereafter. Staff will also be trained on detecting change in physical conditions such as aspiration pneumonia, and when to call the Nurse. To ensure future compliance, the Area Manager will refer all new staff at the home to the Community Services Nurse, who will ensure staff are trained on all	05/31/2013

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	and I did give her meds of nasal spray (saline) but it still seems that her nose is stuff (sic). I (day service Health & (and) Safety Technician) call (sic) the nurse to come over and assess." -3/14/13 "The staff noticed when [client #3] came in she was shaking and not looking well and looking right. the (sic) staff notified the health tech (technician). The health tech took [client #3's] temperature which was a high temp (103.5) and immediately called the residential nurse. The health tech tried giving [client #3] crushed Tylenol (fever) with applesauce but she would not take it. 911 was called. The nurse took [client #3's] temperature which was 103.8. The nurse assessed [client #3] by checking her lungs which was (sic) clear and checking her abdomen which was soft. The EMT's (Emergency Medical Technicians) arrived and took [client #3] to [name of hospital]." Client #3's hospital records were reviewed on 4/18/13 at 2:00 PM. Client #3's 3/14/13 ED (emergency department) notes indicated client #3 chief complaints in the ER (emergency room) were the following: "-Fever -Shortness of Breath		medical needs for the home. Documentation will be forwarded to the Area Manager to assure completion.	

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	-Cyanosis (blue or purplish discoloration of skin) -Blood infection...She was sent here because of fever and low oxygenation. It is not known how long her symptoms have persisted...." The ED note indicated a physical was completed in the ER. The ED note indicated the following (not all inclusive): "B/P (blood pressure) 78/36/Pulse 79/ Temp(Src) 102.4 F (Fahrenheit) (39.1 C (Celsius) (Rectal)/ Resp (respirations) 14...SpO2 (room oxygen) 78%...." The ED note indicated client #3 was "Lethargic" and had "Mottled (patches of skin irregular in color) skin, cool extremities...." The 3/14/13 ED note indicated "Patient is here with hypotension and fever and clinically consistent with sepsis. We'll get labs, lactic acid and blood cultures. We'll give IV (intravenous) fluids and look for source...Pt (patient) has infiltrate on right side....also w/UTI (Urinary Tract Infection)....Dx (diagnosis) sepsis secondary to pneumonia, UTI." Client #3's ED note indicated client #3 was admitted to the hospital's Intensive Medical Care Unit. Client #3's 3/15/13 Infectious Disease Consult Note indicated client #3 had "Mild patchy pneumonia in the right mid lung field. There is also minimal			

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	pneumonia in bilateral hilar and perihilar regions in lung bases...development of pneumonia bilaterally...." The consult note indicated client #3 had bilateral pneumonia and aspiration pneumonia needed to be considered. The consult note indicated a swallowing evaluation was ordered. Client #3's 3/18/13 Clinical Swallow Study indicated "...Previous MBS (Modified Barium Swallow) was completed on 8/22/12 with recommendation for ground diet/mechanical soft (gravy to meats) and thin liquids." The study indicated client #3 was not able to follow directions...Nectar: Pharyngeal (slightly delayed cough after the swallow with a straw) Puree:...Pharyngeal: (intermittent and delayed cough after the swallow)...Recommend modified barium swallow to r/o (rule out) aspiration). Recommend keep NPO (nothing by mouth)...." Client #3's 3/19/13 SLP (Speech Language Pathologist) Modified Barium (Cookie) Swallow indicated "...Last swallow evaluation was a Clinical (Bedside) Swallow Evaluation 3/18/13 which revealed coughing after the swallow-suspicious for possible aspiration. Last known Modified Barium			

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	Swallow Study 8/22/12 revealed no aspiration or laryngeal penetration but revealed pharyngeal residue which patient reportedly cleared independently with via dry swallow." The MBS indicated client #3 was not able to follow commands. The MBS indicated the following (not all inclusive: "Consistencies Assessed: Thin...Pharyngeal: Delayed Swallow. Silent laryngeal penetration during the swallow. Nectar...Pharyngeal: Cough-Immediate due to patient's sensing pharyngeal residue after the swallow. Puree...Pharyngeal: Cough-Immediate due to patient sensing pharyngeal residue after the swallow. Solid...Pharyngeal: Cough-Immediate due to patient sensing pharyngeal residue after the swallow...." The 3/19/13 MBS indicated client #3 had "...Pharyngeal Dysphagia: Moderate Risk of Aspiration Secondary to:: (sic) Orally dysphagia, Pharyngeal dysphagia, and Cognition Compensatory Swallowing Strategies: Patient did not follow commands or compensatory techniques...Recommendations: Diet Recommendations NPO: Yes, due to			

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	patient's inability to use compensations for safety. Speech Therapy for swallowing not recommended due to patient's inability to follow commands for use of compensatory techniques for safety." A 3/20/13 Physician Progress Note indicated "...Patient's condition is guarded. Failed cookie swallow...Plan 1. For (sic) Peg (feeding tube)." Client #3's 3/21/13 Modified Barium (cookie) Swallow impression indicated "Impression: Episode of laryngeal penetration seen with thin liquid presented with sip cup. No aspiration seen. Rest of examination showed no laryngeal penetration or aspiration. Stasis in vallecula (chronic severe oropharynegeal (oral part of the airway) dysphagia) persist during the examination. Assessment/Plan:...Keep NPO (nothing by mouth) for now. Patient may be aspirating. Speech therapist evaluation noted...Patient failed cookie swallow. For PEG tomorrow." Client 3's 3/27/13 Discharge Summary indicated client #3 was on bolus tube feedings. Client #3's discharged diagnoses included, but were not limited to, Sepsis, Bilateral Pneumonia...."			

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	During the 4/16/13 observation period between 5:10 PM and 7;30 PM, at the group home, client #3 sat in a wheelchair. At 6:15 PM, staff #1 took client #3 to her bedroom to give her her medication via the peg tube and then to do the client's bolus feeding. Staff #1 placed a syringe into the peg tube to check for residual. The staff pulled the syringe to 30 and then stopped. Staff #1 then used a small amount of water to flush client #3's peg tube. Staff #1 poured client #3's dissolved medications into the syringe, flushed and poured 2 cans of Jevity, a little at a time, into the syringe. Staff #1 then flushed the peg tube, with the remainder, of the 300 cc of water after the feeding. Client #3's peg tube opening had gauze around the raw opening. Interview with staff #1 on 4/16/13 at 6:15 PM stated she was instructed to only "pull up halfway and stop." The syringe had cloudy liquid up to the 30 mark. Staff #1 indicated they did not measure residuals amounts. Staff #1 indicated they could feed the client as long as the liquid in the syringe did not have "Jevity (liquid food) color." Staff #1 indicated client #3's peg tube opening was cleaned every morning. Staff #1 stated "a little blood is ok. If smell or drainage changes color, call nurse." Staff #1 stated she used a "Q-tip" to clean around the opening. Staff #1 picked up a wash cloth which was on the			

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	dresser and said some staff used a wash cloth. Staff #1 stated the wash cloth was "abrasive." Client #3's record was reviewed on 4/17/13 at 11:41 AM. Client #3's undated Caring For A J-tube And When To Call Your Nurse and/or 911 sheet indicated "[Name of another client not from this group home] has a Jejunostomy (J-tube) which is a procedure that creates a small opening through the outer stomach into the small intestines...1. Gather all supplies needed: medications, water, gloves, 30cc (cubic centimeter) med cup, pill crusher, syringe with bottle, etc...2. Universal precaution (wash hands before and after each task and water gloves) 3. Check the skin around the site for signs of infection. These may include: -Site is more tender and painful -Increased redness or swelling -Drainage that is green in color or foul smelling odor -Excessive leakage around the tube. **If staff notices any of the above signs of infection contact your nurse immediately. **Make sure that you keep the skin around the tube clean and dry. Clean the skin around the site with plain water...**If [name of other client] J-tube is pulled out CALL 911 IMMEDIATELY. **If J-tube becomes blocked or clogged and staff cannot unblock it call your nurse and the			

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	nurse will give staff further instructions...." At the top of the undated instruction sheet, a hand written statement indicated "Work Instructions for Peg & J tube feedings." An instruction sheet for giving Medications and Feedings with J-Tube or Peg Tube indicated "...2. Checking for placement of the J-tube or peg tube staff will need to place the stethoscope on the client stomach above the tubing, remove the knob from tubing and insert the syringe into the tubing use the bulb and slowly inject air into the tubing. Staff will hear a gurgling sound which will let you know the tubing is in the correct spot...." The instructions sheet indicated facility staff were to flush the tube with 30ml of warm tap water before all feedings or medications to ensure the peg tube was not clogged. The instruction sheet also indicated crushed pills were to be dissolved in 15cc of warm tap water and then flush with 15cc of warm tap water. The instruction sheet also indicated the peg tube was to be flushed with 30ml of warm tap water after each feeding. The above mentioned undated instruction sheets were located in a folder in client #3's bedroom for staff to refer to. The facility's time cards were reviewed on 4/17/13 at 2:00 PM. The facility's time			

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	cards/Residential Shifts Worked by Group Home indicated staff #7, #8 and #9 had worked at the group home since client #3 returned to the group home with a peg tube on 3/28/13. The facility's inservice/training records were reviewed on 4/16/13 at 11:47 AM. The facility's Individual Training/Group Training Report indicated the facility's nurse conducted an inservice on 3/28/13, with the staff at the group home, for 2 hours on "Feeding Tube." The inservice forms indicated LPN #1 conducted the training. The facility's Individual Training Reports indicated staff #7, #8 and #9 had not been trained in regard to client #3's feeding tubes/health needs. Staff #9's 3/28/13 Individual Training/Group Report indicated "[Client #3] not eating reg (regular) food, 5cc water for meds 60 water (sic) Must stay up 30 (degrees), Turn (sic) 2 hr., Change (sic) dressing every night. Call 911 if pull tub (sic) out." The form indicated "Were the materials provided effective? No." The 3/28/13 form indicated staff #10 documented "Not comfortable doing it." The form was signed by the staff's supervisor. The form failed to indicate staff #10 was provided additional training to understand and/or perform the medical treatment/procedure to the best of her ability. Review of the 3/28/13 staff			

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	15G559	A. BUILDING 00 B. WING	05/03/2013

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	inservice forms indicated facility staff had been told to dissolve the client's medications in 5cc of water versus the 15cc of water as indicated by the undated instruction sheets. The facility's inservice/training record indicated day service program staff were trained in regard to client #3's feeding tube on 4/8/13 for 20 minutes by LPN #1. The 3/28/13 and 4/8/13 training reports neglected to indicate the nursing services conducted competency based training (monitored/checked off staff) to ensure each staff understood how to care for client #3's peg tube and/or do peg tube feedings. The facility's facility's training reports also indicated nursing services did not ensure facility staff were trained in regards to aspiration/aspiration pneumonia. Interview with the Nurse Manager (NM) and the Director of Health Care Services (DHCS), LPN #1, SC #1 and the Program Coordinator (PC) on 4/17/13 at 3:50 PM indicated client #3 received a peg tube while hospitalized in 3/13. LPN #1 indicated client #3 was last hospitalized for Aspiration Pneumonia and returned to the group home on antibiotics. LPN #1 and the NM indicated facility staff and the day program staff had been trained in regard to client #3's peg tube. When			

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	asked if nursing staff had conducted competency training to ensure staff understood and/or fed the client correctly, LPN #1 indicated competency training had been conducted with staff #1 only. LPN #1 indicated no competency training had been done with the other staff in the group home and/or day program. When asked if staff had been trained in regard to aspiration pneumonia, LPN #1 stated "No." 9-3-6(a)			

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W000369	483.460(k)(2) DRUG ADMINISTRATION The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error. Based on observation, interview and record review for 1 of 26 medications administered, the facility failed to administer a medication to client #2. Findings include: During the 4/16/13 observation period between 5:38 AM and 8:45 AM, at the group home, staff #2 administered client #2's morning medications. Staff #2 did not administer Docusate Sodium (stool softener) to client #2. Client #2's Medication Administration Record (MAR) was reconciled on 4/19/13 at 8:45 AM. The April 2013 MAR indicated client #3 was to receive Docusate Sodium 100 milligrams in the morning. Staff #2 did not administer the client's Docusate Sodium. Client #2's record was reviewed on 4/19/13 at 3:58 PM. Client #2's 3/19/13 physician's order indicated client #2 was to receive Docusate Sodium 100 milligrams twice daily in the morning and in the evening.	W000369	The Community Services Nurse will train all DSPs on proper medication administration in accordance Core A of Living in the Community and Physician's order by 5/31/13. Training will involve modeling, and return demonstrations and will be documented. The Community Services Nurse will monitor each staff performing a medication pass per week for four weeks, monthly for two months and periodically thereafter. In addition the Nursing Department will review the MAR weekly, once proficiency has been established reviews will occur biweekly then monthly thereafter.	05/31/2013

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	Interview with staff #2 on 4/16/13 at 8:45 AM indicated client #3 did not receive the ordered Docusate Sodium at the morning medication pass. Staff #2 stated the Docusate Sodium "was in with the night meds." 9-3-6(a)			

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W000448	483.470(i)(2)(iv) EVACUATION DRILLS The facility must investigate all problems with evacuation drills, including accidents. Based on record review and interview for 2 of 2 sampled clients (#1 and #2) and for 2 additional clients (#3 and #4), the facility failed to address concerns/problems with overnight (11:00 PM to 7:00 AM) fire drills. Findings include: The facility's fire drills were reviewed on 4/16/13 at 2:00 PM. The facility's fire drills from the past year (4/12 to 4/13) indicated the following concerns with the overnight shift drills for clients #1, #2, #3 and #4: -4/23/12 "The clients responded well but the difficult part was getting the wheelchairs through the doors & (and) leaving the clients outside without a staff making sure they are safe as I went & out." The report indicated the area manager reviewed the report on 5/9/12. -4/29/12 "Overnight 1 staff a lot of heavy lifting to (sic) much for one staff. Client is left unattended in dark by mailbox." The report indicated the area manager reviewed the report on 9/24/12. -8/19/12 at 3:01 AM, "It was difficult (to)	W000448	Area Manager and Service Coordinator will review concerns raised during fire drills and will develop plans to modify the environment to address those concerns by 5/31/13. Staff will be trained on these modifications and will show proficiency in their implementation by 5/30/13, Area Manager will observe a fire drill monthly until such time staff and clients are able to evacuate the building safely. Once proficiency in evacuations is established monitoring of fire drills will be faded to quarterly. Recommendations will be made to ensure the safety of all clients and staff during overnight fire drills.	05/30/2013

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	go in & out through the closed doors with the wheelchairs. It was even harder trying to open & hold the door while moving the clients in the wheelchair. I really hate leaving the clients unattended." The report indicated the area manager reviewed the report on 9/24/12. -10/7/12 at 11:33 PM, "Difficult with [client #2] & [client #3] because 1 staff had to stay out with client while the other went to get the other clients." The report indicated the area manager reviewed the report on 4/9/13. The above mentioned reports did not indicate any recommendations and/or corrective actions taken. Interview with administrative staff #3 on 4/19/13 at 3:28 PM stated "We went to double staffing." Administrative staff #3 indicated there used to be cameras in the home with asleep staff at night. Administrative staff #3 stated "We took cameras out back in fall." Administrative staff #3 did not provide any additional documentation and/or interviews in how the facility addressed the overnight shift concerns at the home. 9-3-7(a)			